Original: 2542

Gelnett, Wanda B.

From: Schalles, Scott R.
Sent: Tuesday, July 11, 2006 8:04 AM
To: Gelnett, Wanda B.
Cc: Wilmarth, Fiona E.; Wyatte, Mary S.; Leslie A. Lewis Johnson
Subject: FW: Comments - Chapter 127

Comments of Insurance Federation of PA on #2542

-----Original Message-----
From: Samuel R.. Marshall [mailto:smarshall@ifpenn.org]
Sent: Monday, July 10, 2006 4:50 PM
To: Smith, James M.; Schalles, Scott R.
Subject: FW: Comments - Chapter 127

Gentlemen:

Start your engines and all that. Attached are our comments on the Bureau's proposed revisions to Chapter 127 – long, even by Federation standards, but reflecting that this is a long regulation dealing with some pretty technical but critical areas. The second two attachments are earlier comment letters we sent to the Bureau in 2003 and 2004, referenced by the Bureau in the preamble although not in the content of the regulation. I mentioned them in my letter and incorporated them by reference.

I am forever amazed that the Insurance Department has been able to implement a roughly similar law (albeit without the 1994 freeze) with a relatively simple regulation, with minimal staffing, and with zero complaint from any of the interested parties – and yet the bureau has never once asked of its sister agency, gee, how do you do it?

Good luck, Sam

----Original Message-----
From: Samuel R.. Marshall
Sent: Monday, July 10, 2006 4:42 PM
To: 'Wunsch, Eileen'; 'ra-li-bwc-administra@state.pa.us'
Subject: Comments - Chapter 127

Eileen:

Attached are our comments – as noted, submitted on behalf of our members and the national trades (the PCIA and the AIA).

Please include us on any and all submissions to the IRRC with respect to this.

Thanks, and we hope to work through these concerns with the Bureau.

Sam

Original: 2542

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Samuel R. Marshall
President & CEO

July 10, 2006

Eileen Wunsch, Chief
Health Care Services Review Division
Bureau of Workers' Compensation
Department of Labor and Industry
Comments, P.O. Box 15121
Harrisburg, PA 17120

Re: Chapter 127 - proposed regulation

Dear Eileen:

On behalf of our member companies and several national trade associations with overlapping membership, we offer the following comments on the Bureau's proposed revisions to Title 34, Chapter 127, the Medical Cost Containment chapter of the Bureau's regulations.

As a general comment, we appreciate the Bureau's recognition of the need to revise this chapter. The medical cost containment provisions of the Workers' Compensation Act were intended to do just that - contain medical costs.

Unfortunately, the implementation of those provisions, as set forth in the current Chapter 127 and as implemented by the Bureau, has created considerable confusion, cost and administrative problems for all parties (including, I suspect, the Bureau) - which hardly furthers the goal of cost containment and ill-serves all parties governed by the Act. That situation has only gotten worse, particularly as the Bureau has struggled with implementing the 1994 Medicare freeze, a struggle shared by insurers and, to a lesser extent, providers.

Equally unfortunate, the Bureau - while recognizing that the current regulation needs change - has not fully engaged with at least this segment of the regulated community on what those changes should be, with the result being a proposed regulation that is different but no better than the current one.

On December 2, 2003 and September 10, 2004, we submitted letters to the Bureau at its request recommending changes to Chapter 127; copies of those letters are attached and should be considered as part of our comments here. As the Bureau notes in its preamble, we also spoke at the Bureau's September 16 meeting of stakeholders.

No dialogue, however, emerged from those comments or that meeting. To the contrary, the meeting was emblematic of the problem: While several of the stakeholders spoke, the Bureau did not, and it did not respond to the aforementioned letters that were part of the meeting.

That lack of dialogue has resulted in a proposed regulation that contradicts the Bureau's statement that the regulation will reduce costs to the workers compensation community and ease the administrative burdens. We believe this proposed regulation perpetuates and increases rather than resolves the confusion, cost and problems of the current regulation, and that it will produce significant cost increases in the areas it attempts to regulate.

We can foresee cost impact of the proposed regulation in terms of our own administrative and payments costs; we are not sure how the Bureau reached its conclusion of reduced savings, at least for the insurance community, given that it never asked. We also believe the Bureau itself will experience cost increases, whether in calculating reimbursements (its charge master), implementing its fee review provisions (with new powers and protocol regarding orders), or with all the utilization review changes (as with the proposed precertification program).

We recommend the Bureau detail for all those reviewing this regulation its costs (and the cost of any vendors it uses)

under the current regulation and under the proposed regulation. We also recommend the Bureau compare those costs with those of the Insurance Department in implementing similar provisions under Act 6 of 1990. That would allow for a more complete evaluation of the cost effectiveness of this proposal.

Section 5(a) of the Regulatory Review Act, 71 P.S. Section 745.5, lists a number of factors that an agency should include in its regulatory analysis form that accompanies a proposed regulation. Among these are an identification of the financial and economic impact of the proposed regulation and an evaluation of its benefits, a description of any alternative regulatory provisions that were considered, and a description of the plan developed for evaluating the regulation's continued effectiveness.

Those factors are conspicuously absent in this proposed regulation. That reflects, we believe, the lack of meaningful dialogue between the Bureau and those it regulates (or at least the insurance community). It highlights that this regulation is simply not ready even for the proposed stage of the IRRC process. All parties - including the Bureau - would benefit from a meaningful dialogue on the problems with and potential solutions to the current and the proposed regulations.

We note that the Bureau has had, since this regulation was published in the June 10 Pennsylvania Bulletin, a meeting of at least some stakeholders on June 29. Further, it is hosting three open sessions on July 10, 11 and 13 across the Commonwealth - with all four forums promising the opportunity for meaningful comment on the proposed regulation.

Those forums should have happened before this regulation was submitted to the IRRC, at least if they were truly intended to have any value. They should also allow for dialogue, not just comment - which did not happen at the July 29 meeting - and at least the comments should be shared with the IRRC and made part of its review.

Nonetheless, despite the limited value of these forums, they do highlight that this proposed regulation should be withdrawn to at least consider the comments that are submitted at them. Otherwise, what is the purpose of the forums, given the Bureau's silence at them?

The ultimate test for this regulation is whether it is in the public interest as measured by the standards in Section 5b of the Regulatory Review Act, 71 P.S. Section 745.5b: First, does the Bureau have the statutory authority to promulgate this regulation, and does the regulation conform to the legislative intent behind the underlying statute. And second, if those questions are answered in the affirmative, what are its economic and fiscal impacts, and how clear, feasible and reasonable are its requirements.

We believe this regulation fails to meet those standards. Its pronouncements on determining medical payments and reviewing medical utilization are often without legislative support and almost always inflationary despite the underlying statute's goal of medical cost containment. Further, its pronouncements are often confusing and conflicting and ambiguous, to detriment of providing the clear set of rules that all of us - whether insurers, employers providers, or injured workers - need.

As to specific sections of concern:

Subchapter A - Preliminary Provisions

Section 127.3 - Definitions

"Audited Medicare cost report": We are confused by the proposed additional phrase of a successive mechanism used by Medicare. This suggests changes in cost reimbursement that float with changes in Medicare, whereas other parts of the regulation dogmatically hold to the Medicare freeze. We believe that inconsistency is unfair: While we support going to "floating Medicare", we believe it should be done consistently, not on the piecemeal and inflationary basis that appears here.

"Bureau code": The phrase "authorized to provide services" is an awkward one. Insurers, at least, are licensed to provide coverage, not authorized to provide services.

"CCO": We recommend continuing the reference to the statutory authorization of CCOs.

"Charge master": As will be detailed in the sections dealing with the charge master, we believe this is an incomplete definition and recommend it be revised to specifically address how it is intended to deal with post-1994 revenue centers of the covered providers.

"Explanation of reimbursement": The reference to "a format prescribed by the Department" suggests a format exists or is under development. If the former, specific reference to it should be made; if the latter, it should be produced along with this regulation - otherwise, this becomes a definition that fails to fully define.

New formats create, potentially, significant programming and other administrative costs for insurers. While this regulation suggests several new forms, it discloses none of them (and the preamble says there will only be one new form)- highlighting the problem of projecting the cost of this regulation or its practicality, two areas the Bureau nonetheless assures are satisfied in its preamble.

"Medical records": We are confused by the reference to information that "accurately, legibly and completely" reflects the evaluation and treatment of the patient. Those are subjective terms - and should at least be clarified as to who decides whether they have been met. Further, we are confused by the second sentence's reference to people not "actually" providing patient care. What does "actually" add to that standard, beyond the potential for confusion and argument?

"Medical reports": We recommend this be revised to include treatment and service rendered "and any future treatment plan". Further, we recommend this be revised to include information on "current functional work capabilities and future functional rehabilitation plans". These reports - such as a functional capacity checklist - should not be considered special reports under Section 127.130.

"Medical Report Form": What form is the Department designating here? Is it the LIBC-9 form, or something still to come? If the former, the definition should reference it; if the latter, it should be produced along with this regulation.

"Notification of disputed treatment": We recommend the reference to an EOR be clarified to be limited to those situations where there is a filed claim.

"Precertification": This creates a new subset of prospective review, exclusive to employees and providers. In the relevant sections, however, it emerges not as a subset of prospective review but a separate process. We have concerns with that - but in any event, its definition should be distinct from "prospective review", because it is treated that way in the relevant sections.

"Treatment": This seems incomplete in some ways and too broad in others. We recommend it be revised to refer to "work-related diseases or injuries".

"Usual and customary charge": The additional phrase "as evidenced by a database published or references by the Department in the Pennsylvania Bulletin" suggests such a database exists, but none has been forthcoming, and the regulation suggests no details or time frame for this. Absent the Bureau's doing this, the definition is meaningless. We recommend the regulation include, not just promise for some undetermined future time, the database.

Subchapter B - Medical Fees and Fee Review Calculations

Calculations

Section 127.101 - Medical fee caps - general

We have voiced our concern about this on numerous occasions, so it will be no surprise: This regulation perpetuates 1994 Medicare reimbursement mechanisms that are not just outdated, but increasingly impossible and unreasonable to use.

Only Pennsylvania workers compensation still relies on the 1994 Medicare reimbursement mechanisms required by this regulation. Nobody else in Pennsylvania or across the country uses this. That makes understanding and administering these mechanisms not just impossible and unreasonable, but expensive - and not just for insurers and self-insured employers, but for providers and the Bureau. The cost is administrative, with no benefit to injured workers either in benefits or ensuring access to quality care. The wasted administrative cost is borne by insurers and employers.

The only beneficiaries are pockets of providers for whom these outdated Medicare mechanisms produce somewhat (and randomly) higher reimbursement levels than do current mechanisms. We do not believe such random rewards were the intent of the General Assembly, and they should not be furthered by this regulation.

Accordingly, we renew our request that the Bureau revise this section (and the others tied to it) to use current Medicare methodologies. In the past, the Bureau (or at least the Department) supported legislation doing this, but has felt a regulation doing so would be inconsistent with current law. We also ask that you revisit this position: A regulation should make a statute capable of reasonable implementation, not perpetuate an impossible, unreasonable and increasingly absurd standard that benefits nobody.

The Bureau, in other sections of this proposed regulation, seems to adopt current Medicare mechanisms and methodologies, presumably because it believes going with current rather than 1994 Medicare is the only practical means of payment. That should hold true throughout the regulation - or at least the Bureau should explain and justify its basis for distinctions.

Section 127.102 - Medical fee caps - usual and customary charge

Although the Bureau proposes no change to this section, the problems with its definition of "usual and customary charge" apply here: Absent the Bureau's designation of a database, this section is meaningless.

Section 127.103 - Outpatient providers

Subsection (c): As with the previous section, the reference to "usual and customary charge" in this section is meaningless absent a database.

Subsections (e) through (g): These should specifically reference 113% of Medicare, consistent with the Act, or be more clearly tied to the subsequent sections.

Subsection (g): The reference to "calendar years of the effective date of the new codes" is confusing. It should clarify that the applicable rate is for the date the code was introduced, not when it was discovered (which might be a later date and a different rate). This concern holds true for Sections 127.104(d), 127.105(h), 127.106(f), 127.107(d) and 127.108(d).

Section 127.104 - Outpatient providers - physicians

Subsection (a): The addition of "initially" is confusing, unless more clearly cross-referenced to Section 127.103.

Section 127.105 - Outpatient providers - chiropractors

Generally: As with Section 127.104, the addition of "initially" is confusing, unless more clearly cross-referenced to Section 127.103.

Subsection (c): This should clarify that it only applies to chiropractors with the appropriate adjunctive procedures license.

Section 127.109 - Supplies and services not covered by the fee schedule

The Bureau is perpetuating rather than addressing a major problem in medical payments, that of excessive costs and provider mark-ups for durable medical goods. Further, the reference to "usual and customary charge" is meaningless, as elsewhere, because of the lack of a database.

We recommend the section be revised to specify that the provider's documentation include the invoice showing his own cost; the section should then allow an inflation factor (Tennessee and Georgia have good regulations on this). Otherwise, providers are allowed to be retailers for these supplies with no controls, hardly consistent with the cost containment goal of the Act.

Further, this section should be revised to clarify that the reference to a "provider's usual and customary charge" is to be based on the usual and customary charges of providers generally, not each individual. That collective aspect is in the Act and in the definition of "usual and customary"; it should be clarified whenever, as in this section, the term is used.

Section 127.111a - Inpatient acute care providers - DRG updates

Generally: This proposal, at least as we read it, is best described as "being a little bit pregnant." On the one

hand, the Bureau insists on staying with frozen Medicare rates; on the other, it proposes going to current DRG Groupers.

These are two fundamentally inconsistent and incompatible concepts and systems, hard to administer and, we believe, inflationary in terms of payments for these providers. To the extent the Bureau feels compelled or empowered to adopt current DRG groupers, we believe it should feel equally compelled and empowered to adopt the rest of current Medicare reimbursement methodologies. The 1994 freeze should not be selectively administered, applicable to some parts of Medicare methodologies but not others - and yet that is what this section proposes, something that is unworkable and unfair in terms of cost containment.

The Bureau states that the regulation will have a favorable fiscal impact on the workers compensation community. This section alone belies that contention: We believe the use of current DRG groupers will not only raise the cost of medical payments, but raise the administrative costs of calculating them.

Subsection (b): We believe the inclusion of the added weekly wage annual update is a change from current regulation and a needless inflationary factor; further, as it has not been included in the past, it raises the question of whether the percentage should include average weekly wage increases since 1995. We recommend it be deleted.

Subsection (d): The reference to "cost-to-charge" outliers seems incorrect. We recommend this refer to "cost outliers".

Section 127.114 - Inpatient acute care providers - outliers

The regulation imposes a firm threshold of $36,000, saying this is the applicable Medicare threshold. Is that the current or 1994 threshold? Further, our understanding is

that this threshold changes annually and with individual providers and DRGs.

In any event, this goes to an underlying concern with this regulation: One section uses fixed Medicare aspects, while another goes to current or floating Medicare aspects - with little explanation or seeming rationale.

Section 127.117 - Outpatient acute care providers

Generally: This section introduces the reliance on "service descriptors" to determine reimbursement levels, an unexplained change from the current regulation's reliance on service codes.

We believe this will impose significant administrative burdens and will be impossible in many situations - particularly those involving multiple procedures. That would lead to many more defaults from the fee schedule, which in turn would lead to increased reimbursement amounts (especially given the Bureau's continued inability to develop a "usual and customary" database), hardly the purpose of a regulation that is supposed to promote cost containment.

Subsection (b): This subsection refers to procedures, whereas the other subsections refer to services. Is that a distinction, or a distinction without a difference? We recommend consistent terminology or better explanation of differences.

Subsection (c): Our general reaction to this subsection is one of confusion. We are not sure what constitutes "the appropriate Revenue Code" with which the RCC ratio will be associated, since there are variations within a given Revenue Code from service to service. We believe "Revenue Code" itself may be a flawed term - does the Bureau really mean Revenue Center?

Further, our understanding is that Medicare no longer uses Revenue Codes, but has adopted the Ambulatory Patient Classification system. As a result, new services under this section might not be able to be tied to a Revenue Code, as it might not be part of a hospital's Medicare Cost Audit Report. Would that leave insurers paying at 80% of usual and customary charges? If so, that would be a significant fiscal impact - especially given the inadequacy of the regulation's provisions on "usual and customary".

Subsection (d): Generally, we pay for pharmacy services at 110% of the Average Wholesale Price. That should be continued here.

Subsections (g) and (h): This assumes timely and accurate submission of information from hospitals. That, however, has not been the experience under the current regulation. These sections should clarify what happens if and when hospitals do not submit the information.

Section 127.119 - Payments for services using RCCs

Generally: As with Sections 127.104 and 127.105, the reference to "initially" is confusing unless better clarified or cross-referenced.

Section 127.120 - RCCs - CORFs and outpatient physical therapy centers

Subsection (d): The regulation should explain whether this will produce different reimbursements than under the current regulation and, if so, why the change is needed.

Section 127.121 - Cost-reimbursed providers - medical education

Subsection (d): Again, the regulation should explain whether this will produce different reimbursements than

under the current regulation and, if so, why the change is needed. Further, this subsection provides no guidance on how this is to be monitored as to whether a provider is still receiving add-on payments, has lost his right to them, or has started to get them. Some form of verification and updating should be required.

Section 127.122 - Skilled nursing facilities

Subsection (b): As with Section 127.111a(b), we believe the inclusion of the added weekly wage annual update is a change from current regulation and a needless inflationary factor; further, as it has not been included in the past, it raises the question of whether the percentage should include average weekly wage increases since 1995. We recommend it be deleted.

Section 127.123 - Hospital-based and freestanding home health care providers

Subsection (b): As with Section 127.111a(b) and the preceding section, we believe the inclusion of the added weekly wage annual update is a change from current regulation and a needless inflationary factor; further, as it has not been included in the past, it raises the question of whether the percentage should include average weekly wage increases since 1995. We recommend it be deleted.

Section 127.124 - Outpatient and end-stage renal dialysis payment

Subsection (c): As with Section 127.111a(b) and the two preceding sections, we believe the inclusion of the added weekly wage annual update is a change from current regulation and a needless inflationary factor; further, as it has not been included in the past, it raises the question of whether the percentage should include average weekly wage increases since 1995. We recommend it be deleted.

Section 127.125 - ASCs

Generally: As with Section 127.111a, this section seems to be "a little bit pregnant" - at least in its use of Medicare. Since there have been many new payment groups since 1995, this suggests that current Medicare will be used - but that belies the other sections which insist on relying on 1994 Medicare.

That, again, goes to an overriding objection we have with this regulation: It seems to acknowledge that 1994 Medicare is outdated and impractical, at least in certain situations; but it sets forth no discernable guide for when it will therefore adopt current or floating Medicare.

That makes it incapable of execution and, so far as those of us who have to determine payments under this can figure, inflationary. It also highlights the problem of statutory authority: The Bureau has repeatedly claimed it cannot abandon the 1994 rate freeze because of statutory restrictions, despite the obvious impracticality of that freeze - and yet, at least in certain situations such as here and Section 127.111a, it does abandon 1994 Medicare. Where is the basis for such selective statutory authority?

Subsection (a): This should clarify that the groups are as of 1994. Further, the phrase "and shall include the Medicare list of covered services and related classifications in these groups" should be retained; otherwise, making calculations is difficult at best. Finally, we are confused by the inclusion of licensure by the Department of Health: Are there ASCs in Pennsylvania that are not licensed? What does this add?

Section 127.128 - Trauma centers

The problem of "usual and customary charge" noted in other sections applies here, too. Without the promised database, these sections are ineffective. Further, as with Section 127.109, this should clarify that it is a collective "usual and customary charge", not an individual one.

Section 127.129 - Out-of-state medical treatment

The proposed deletion of subsection (b) raises the question of how the Bureau will respond to a fee review request from an out-of-state provider. We appreciate the Bureau's position that it has no ability to enforce the fee schedule in these situations; but what will it do when faced with these requests?

Section 127.130 - Special reports

Generally: The key question here is what constitutes a special report, which ties to our concerns with the definition of Medical Reports. Accordingly, those concerns are adopted for this section, too.

Subsection (b): The 80% cap on payments for these reports should be reinstated. Deleting this increases costs.

Section 127.131 - Payment for prescription drugs

Subsection (a): This should also state that pharmacists and physicians are required to supply the National Drug Classification Code, without which insurers are unable to accurately determine the AWP. Further, the reference to "the most recent edition" of the Redbook should be clarified. Our understanding is that this book changes frequently, so the regulation should clarify whether it means the annual edition or interim revisions.

Subsection (c): This should also require that a provider supply documentation supporting the basis for medical necessity where a brand name drug is being used instead of a generic drug.

Section 127.133 - Payments for prescription drugs - effect of denial of coverage

We do not understand this proposed change. It provides little or no guidance as to when it applies, and it should be more fully stated - at least to match the section's title, which is limited to denials of coverage, and to capture that this section only has impact where there has been an initial denial of coverage that is subsequently changed.

Section 127.134 - Payments for prescription drugs and pharmaceuticals - ancillary services of providers

Subsection (a): As this section is truly in the past - it has been obsolete since 1995 - why make a change in nomenclature that means nothing? It makes more sense to delete it, and any other sections that are exclusively pre-1995.

Billing Transactions

Section 127.201 - Medical bills generally

Subsection (c): A rare moment of agreement, and a correspondingly rare moment of provider objection! We believe it is essential, practical and fair to require providers to request payments within 90 days from the first date of treatment on the bill. Given all the time frames on insurers - all of which are tighter than this - it is laughable and a bit disingenuous that providers complain about this.

Section 127.203 - Medical bills - documentation

Subsection (a): The inclusion of "instead" where an employer is covered by an insurer raises a question: Is this intended to prohibit an insured employer from getting the Medical Report from a provider?

Subsection (d): **Subsection (1)** should be clarified to refer to the employee's medical history and any information on the causal relation between his work and the injury. **Subsection (4)** should be revised to refer to the employee's physical capabilities generally, not just his ability "to return to preinjury work without limitations" - a needlessly limiting phrase that suggests other information merits a special report and separate cost.

Section 127.204 - Unbundling by providers

The reference to the Correct Coding Initiative is too limiting. The CCI itself acknowledges that it is incomplete and that other programs (as with Medicare guidelines) provide more detail. Further, CCI should be a defined term.

Section 127.207 - Downcoding by insurers

Subsection (a): The conjunctive requirement of this subsection results in undue limits, as it does not recognize the problem of inadequate documentation; this requires an insurer to have sufficient information to make a code change, but fails to recognize that insurers should also be allowed to make a code change when a provider has not supplied sufficient documentation to support the higher code.

Further, as with Section 127.204, the CCI reference is too limiting; Medicare guidelines should also be allowed, as under the current regulation.

We also recommend this section be revised to expedite any disputes that occur in a downcoding of a provider's codes, and to reconcile the time constraints here with those in Section 127.208 (that same concern holds true with Section 127.206). Our general experience is the process set forth in this section takes a needlessly long time and runs up against the 30 day rule in Section 127.208, especially if the provider is not prompt in his response.

A possible revision would be to change this section to provide that insurers pay the bill as downcoded, with the explanation of the downcoding in the EOR, and with any disputes treated as after-payment disputes to be resolved by dialogue between the insurer and provider and, if that fails, through the fee review process.

Section 127.208 - Time for payment of medical bills

Subsection (b): The three days are inadequate: The mail isn't always that fast, and the timing starts on the faulty (or inadequate) premise that the date of mailing is the date on the bill (as opposed to the date of actual mailing). Insurers note that there is often considerably more time than three days in between the date on a bill and the date they receive it.

This section should at least allow for three business days, and should allow for an exception where the insurer has a routine procedure of date stamping any and all bills submitted - with that date serving as the date of submission.

Section 127.209 - Explanation of reimbursement paid

Subsection (a): As with other sections of the proposed regulation, this speaks of a Department-prescribed format without any indication of what that format will be. If the Bureau is proposing new forms and formats, it should include them in the regulation. Otherwise, it is impossible to evaluate the efficacy of the forms or format.

Subsection (b)(1): An insurer cannot necessarily "disclaim liability for the employee's liability" at the time a provider submits a bill, since the insurer may not have the underlying claim to accept or reject at that time. Those are distinct determinations and should not be merged into EORs.

Subsection (c): The re-pricing systems utilized by insurers do not always have the Bureau Code required here, and we are not sure what it adds in any event. Further, we recommend deletion of the last sentence of the notice; providers may have the ability to apply for fee reviews, but nothing in the Act suggests insurers have an obligation to invite them to do so.

Section 127.211 - Balance billing

Subsection (d): First, we note nothing herein provides sanctions on providers who balance bill; it should at least provide that such situations will be referred to the appropriate licensure boards for action.

Second, the Bureau's reference to violations of the Act and this chapter seems a needless threat rather than a reference to Section 435 that would apply not just to EORs but generally and therefore need not be stated here. In any event, this subsection seems misplaced - it should be in the section related to EORs, not the section related to balance billing.

Review of Medical Fee Disputes

Section 127.252 - Application for fee review - filing and service

Subsection (a): The reference should be to 30 days following the provider's, not the insurer's receipt of the first notification of a disputed treatment. Further, the reference to three days should be changed to three business days.

This section's timing and mailing provisions - as compared with those in Section 127.208(b) and elsewhere - also highlight that the regulation should adopt greater internal consistency. All timing and mailing provisions should be the same. References, as here, to "deposited in the United States Mail" that are not continued elsewhere in the regulation only create confusion.

Section 127.253 - Application for fee review - documents required generally

Subsection (a): **Subsection (1)** should refer to the first disputed bill, not the first bill. **Subsection (3)** should clarify the reference to the EOR "if available": Where an insurer has issued an EOR, the provider should be required to retain it if he wants to file a fee review on it.

Section 127.255 - Premature applications for fee review

Generally: The Bureau is attempting to give itself an administrative power held only by agencies, not divisions of them - the power to issue orders. Further, it apparently intends to do so without adhering to many of the administrative rules in Title 1 of the Pennsylvania Code; notably, it supersedes those rules without offering any replacements - making it impossible to determine how the hearings and process envisioned here would be handled.

We do not believe the Bureau has the statutory authority to do this, especially with initial fee reviews. We also do not believe the Bureau is set up to do this, so it should at least document the cost of adding new personnel for this. The references to administrative orders of the Bureau should be deleted, as should the superseding of the administrative rules in Title 1.

Subsection (a): **Subsection (2)** should delete the reference to "accurately"; it adds only confusion and needless subjectivity.

Section 127.256 - Administrative decision and order on an application for fee review

Generally: Again, the Bureau's proposed creation of the power to issue orders is unfounded and should be deleted, along with its proposed superseding of the administrative rules. As this apparently is on an initial action, referring to it as an "order" is particularly troublesome.

Subsection (a): We are concerned that the Bureau is deleting the 30 day time limit on rendering its fee review decisions. Granted, the Bureau has routinely exceeded that limit. But that doesn't mean the limit should be dropped - it means the Bureau should start following it. As insurers must pay interest for this time period, dilatory decisions are an unfair penalty and, of course, a fiscal impact. We also note the irony of the Bureau imposing time constraints on all other parties while deleting the one on itself.

Subsection (b): If this is going to result in an "order", it should be revised to require the Bureau to obtain an insurer's response - i.e., replacing "may" with "shall". This subsection highlights the absurdity of the Bureau's attempt to issue orders: No order, administrative or judicial, should be issued without affording the party subject to the order the right to be heard - and yet the Bureau asserts that should be discretionary for it.

Subsection (c): This should be revised to require, not just allow, the Bureau to correct its errors within 15 days - again, replacing "may" with "shall". Otherwise, the subsection is meaningless. Further, the 15 days should be 15 days after being notified of the error - and this subsection should provide a clear process for identifying these errors and clarifying that any interest or penalties are tolled while waiting for the correction.

Section 127.257 - Contesting an administrative decision and order on a fee review

Again, the Bureau's proposed creation of the power to issue orders is unfounded and should be deleted, along with its proposed superseding of the administrative rules.

Further, the appeal here is to the Bureau - leading to the nonsensical process of appealing an order of the Bureau to the Bureau. That is not an appeal - it is a requirement that parties file for reconsideration before being allowed to appeal, and that requirement is without authority.

Section 127.258 - Bureau as intervenor

This section further highlights the Bureau's inappropriate attempt to issue orders: The Bureau should not be able to intervene in a matter in which it is issuing an order. Further, with the proposed regulation only superseding administrative rules, not developing new ones, the problems only multiply.

Section 127.259 - Fee review hearing

Generally: We are not sure what rules of administrative practice and procedure remain given the broad superseding language in the proposed subsection (g).

Further, we are not sure if this is the first or second stage of this proposed process. Generally, an agency cannot issue an order unless the parties have been given an opportunity for a hearing. This section, however, read in conjunction with the others in this area, suggests this would be the appeal hearing - really a reconsideration - and that there would be no right to a hearing before the initial Bureau order.

Subsection (a): We question why the Bureau proposes dropping the de novo aspect of these hearings. Are these no longer to be de novo proceedings? If not, what are they?

Subsection (d): We assume this does not require parties to this hearing to have a lawyer; that should be clarified.

Section 127.259a - Fee review hearing - burden of proof

We question why the insurer bears the burden of proof in a fee review hearing. There is no statutory authority for this, especially in the apparent second level of Bureau review created in this proposed regulation. The de novo provisions in the current regulation should be maintained.

Section 127.260 - Fee review adjudications

Again, the Bureau's proposed creation of the power to issue orders is unfounded and should be deleted, along with its proposed superseding of the administrative rules.

Subsection (a): We question the Bureau's proposed deletion of the 90 day time limit. As with the 30 day limit in Section 127.256 (a), the Bureau has routinely exceeded that limit. But that doesn't mean the limit should be dropped - it means the Bureau should start following it.

Section 127.261 - Further appeal rights

If the Bureau itself - as opposed to the Department - is empowered to issue orders, then all such orders may be appealed to the Commonwealth Court, not just orders issued under Section 127.260.

Subchapter D - Employer List of Designated Providers

Section 127.752 - Contents of list of designated providers

Subsection (e): The Bureau lacks statutory authority for this requirement. This confuses a network with a CCO; either one can have a single point of contact, but only a CCO constitutes a single provider. Further, the single point of contact in networks has been to the benefit of employees, as it facilitates answering their questions in getting appropriate care.

There is simply no basis - statutory or practical - for this requirement, other than to discourage the use of networks in establishing physician panels. We recognize the Bureau does not like the use of networks; nonetheless, they are lawful under the Act, and this regulation should not be used to subvert their use.

Subchapter E - Medical Treatment Review

UR - General Requirements

Section 127.801 - Review of medical treatment generally

Subsection (c): Where a provider seeks UR on behalf of an employee, he should be required to have the employee's consent.

Section 127.805 - Requests for UR - filing and service

Generally: This should clarify that an insurer may submit the medical records it has as part of its request for a UR, and that those records will go to the URO, as allowed under similar provisions covering auto insurance. Otherwise, the URO is unable to understand the basis of the insurer's challenge.

Subsection (a): This references "the Bureau-prescribed form". What form? As the Bureau apparently envisions various types of UR, the types of forms should be disclosed incorporated into this regulation.

Subsection (e): The Bureau should put a time frame on when it will accept or reject a request for UR. **Subsection (2)** should be revised to require that the Bureau also identify what it believes to be missing from the UR request. **Subsection (5)** imposes an impossible task: The party requesting a UR does not necessarily know all the providers who rendered care - and certainly the Bureau would not know this. **Subsection (6)** should be clarified to ensure that URs may still be requested with respect to out-of-state providers. The definition of a "provider" in this chapter seems to include only in-state providers; that may hold true for fee schedule issues, but not UR.

Subsection (f): The tolling on an insurer's obligation to pay medical bills should be as of the initial filing of a

UR request, at least where the filing is made by an employee or provider. Otherwise, the insurer is unfairly penalized by the filing mistakes of the employee or provider.

Section 127.805a - UR of medical treatment prior to acceptance of claim

Subsection (b): This suggests that an insurer requesting a UR is liable for the treatment under review even if it is not found liable for the injury being treated. That is not the case, and this should be clarified.

Section 127.806 - Requests for UR - assignment by Bureau

Generally: Time frames are needed here on the Bureau (as with our earlier concerns about sections where the Bureau proposes deleting time frames on it, even as it proposes time frames on everyone else).

Subsection (b): **Subsection (4)** should be clarified that notice will be sent to all providers whose treatment is being challenged in the UR request. Combined with the "all providers" requisite in Section 127.805(e)(5), this suggests that providers not being challenged would nonetheless be getting notice - a needless element.

Section 127.807 - Requests for UR - reassignment

Generally: Again, time frames should be imposed on the Bureau, not just on others.

Subsection (c): This should clarify that the 5 day time frame imposed on UROs in subsection (a) applies here as well.

Section 127.808 - Requests for UR - conflict of interest

Generally: The conflicts identified here are needlessly restrictive and fail to reconcile with the structure of UROs, which often have wide-spread and changing numbers of providers. We believe the ultimate impact of these standards of conflict will be to limit the ability of all parties to promptly utilize the UR process.

We recommend this section be revised to refer to the providers on the URO panel, not the URO itself, in the appropriate sections - especially **subsections (1) and (2)**.

Section 127.809 - Requests for UR - withdrawal

Subsection (b): This is the first time frame the Bureau proposes for itself, and even this is not much of a frame - "promptly" means little. We recommend, consistent with other sections, that the Bureau establish meaningful guidelines on itself as well as on other parties.

Subsection (c): We are not sure why insurers should bear the cost of a withdrawn UR that they did not request; there is no statutory authority for this. We recommend that the party withdrawing the UR request bear its cost.

Further, we recommend that the Bureau establish fees for UROs or at least consider and disclose those fees in authorizing UROs. It should also require that the party losing in a URO request bear the costs, just as the party withdrawing a UR request should bear the cost (where a URO renders a partial decision, the cost should be apportioned among the parties).

Subsection (d): This should clarify that any withdraw with prejudice applies only to those services covered in the UR request, not different or subsequent services.

UR - Entire course of treatment

Section 127.811 - UR of entire course of treatment

Subsection (c): The last sentence requires a URO to consult with involved reviewers to resolve any inconsistencies. That may be reasonable, but conflicts with Section 127.869(c) - so those two sections need to be reconciled.

UR - Precertification

Section 127.821 - Precertification

Generally: This and the following "precertification" sections are establishing a process not envisioned in the utilization review provisions of the Act - a separate process for prospective UR if requested by an employee or provider, given a separate title ("precertification") and separate and conflicting rules and standards.

We recommend the Bureau delete this new process and stay with what is authorized in the Act - prospective review. In any event, the Bureau should detail how this differs from prospective review, and its authority to create a new type of review not contemplated in the Act.

We also note the Bureau's plan to consolidate into one review separate requests by a provider and an employee. The Bureau does not have that authority - or at least it then needs to answer the question of whose request this becomes. This could be resolved by adopting our recommendation for Section 127.801(c) to require that a provider first obtain the consent of the employee before filing a request for UR.

We also note the different language here than in other sections controlling insurer-requested prospective review: This speaks of "treatment not yet provided". Other sections speak of treatment the employee "may undergo in the immediate future". Is there a difference?

Section 127.822 - Precertification - insurer obligations

Generally: This appears to establish a preliminary process to a request for prospective UR when the request comes from an employee or provider, but the language is confusing. If this is a preliminary process, we object to it as lacking statutory authority and as creating needless conflict with other prospective URs. Further, it is unclear who pays for the UR in this setting, or whether this is even UR.

Subsection (a): This refers to a "request for prospective review". That may be an editorial problem - this section deals with requests for precertification, whereas requests for prospective review appear to be limited to insurers in subsequent sections: Is the Bureau proposing that when an insurer requests prospective review, the provider or employee can counter with a request for precertification? This seems to invite needlessly overlapping and conflicting URO review of the same treatment.

It highlights the problem of this new process: It needlessly conflicts with general provisions of prospective review, and this and the following subsections create a new tier - a process preliminary to a prospective by an employee or provider - that may subvert an ongoing request for a prospective review.

Further, **subsection (a)(1)** talks about a "Bureau-prescribed form"; as with other forms referenced throughout this regulation, this should be included here. In particular, it is unclear what medical records will be used - are they different than those that would be required in a request for precertification or prospective UR?

Subsection (a)(2) imposes a 10 day requisite, going to when the request for precertification was mailed; that is a tough time frame, and the employee or provider should at least be required to use certified mail, not just allowed to use the Proof of Mailing form set forth here. With many insurers having multiple offices, the lack of a firm mailing process combined with a tight time frame is inordinately prejudicial to insurers.

Subsection (c): The requirement that an insurer pay for treatment if it fails to respond within 10 days is a needless change from the current regulation, which allows the UR to continue, albeit without the insurer's documentation. This again highlights the one-sided nature of the proposed precertification process.

Subsection (d): This confuses decisions regarding medical treatment with those regarding causal relationships and underlying liability. Those latter issues are legitimate, of course - but this subsection tied to a preliminary process to UR requests is not the appropriate place to impose penalties.

Subsection (e): This highlights the confusion of this new, apparently two-tiered, precertification process. It speaks of an insurer not agreeing to pay for treatment without contesting liability or causation - presumably something that happens under the process of the preceding subsections, and apparently without the employee or provider submitting medical records - with the employee or provider then being able to request a precertification. But it should only happen if, at least, medical records are submitted.

Further this subsection does not deal with the possibility of an ongoing request for prospective review of the same treatment that might be the subject of a request for precertification - despite inviting that conflict in subsection (a).

Subsection (f): This should be deleted or clarified. An insurer might deny payment under this section for a variety of legitimate reasons (inadequate information, incomplete forms, no causal relationship, etc.) and would not be subject to penalties, even if the treatment were later determined to be reasonable and necessary.

Section 127.823 - Precertification - provider-filed requests

Subsection (a): The reference to "the form" raises the question of which form - that in the previous section, or that in Section 127.805 for UR requests?

Subsection (c): How does this differ from the Bureau's return of UR requests generally set forth in Section 127.805? If there is no difference, this subsection should be deleted; if there is a difference, it should be explained.

Section 127.824 - Precertification - employee-filed requests

As with many other sections, this lacks time frames for integral parts of the UR process - as with how quickly the URO should contact the provider. As with those other sections, time frames should be supplied here.

Section 127.825 - Assignment of proper requests for precertification

First, whether and why these rules differ for precertification and other prospective UR requests should be clarified. Second, time frames are needed.

Prospective, concurrent and retrospective UR

Section 127.831 - Prospective, concurrent and retrospective UR - insurer requests

Generally: Our concerns with this section mirror those of the preceding sections establishing a two-tiered "precertification" process for employees and providers. Nothing in the Act suggests such disparate treatment.

Further, this section invites inevitable conflict between a precertification request and a prospective UR request - especially given that the timing in both is presumably different (prospective review does not have two tiers, unlike precertification). It also raises the question of whether concurrent and retrospective UR is limited to insurers, or whether providers and employees also have the right to request such reviews.

Subsection (a): With respect to prospective review, this suggests a difference with the precertification available to employees and providers. Insurers may request this for treatment the employee "may undergo in the immediate future", whereas employees and providers may do so for "treatment that has not yet been provided". That conflicting language needs to be reconciled. Further, while the caption of this section includes retrospective review, this suggests applicability to only prospective and concurrent review.

Subsection (b): Is the "requester" here only the insurer, or does it include employees and providers? Again, this goes to the question of whether employees or providers may also request concurrent and retrospective review. Further, this subsection states that the Bureau's nonassignment of a UR is subject to appeal only after the UR determination is rendered; that is impossible and should be explained.

Section 127.833 - Continuing effect of UR determinations

Generally: The timing here - whether for approvals or disapprovals - seems inconsistent with the 180 day outer limit imposed in Section 127.864(d).

Subsection (a): This duration - "only to the extent specified in the determination" - conflicts with subsections (c) and (d) - "until the employee demonstrates that a change in the employee's medical condition merits redetermination." Granted, this deals with approvals while

the other subsections deal with disapprovals - but why not the same standard for duration?

Subsections (c) and (d): These subsections rely solely on a change in the employee's medical condition. That, however, should not include changes that might be due to non-work-related injuries. Further, it leaves unanswered who determines there has been a change and where it should be shown - by the judge, or by the URO to whom the request is made?

Further, it is unclear why subsection (c) requires the employee to demonstrate a change, whereas subsection (d) - which presumably deals with only instances where there have already been two reviews (initial and redetermination) - allows the change to be shown by either the provider or the employee.

Requests for UR - Recertification and redetermination

Section 127.841 - Requests for UR - recertification

Subsection (a): We assume, but are not sure, that this applies only to a "recertification" of a "precertification" that was approved. If so, it should be limited to a recertification of treatment that goes past the duration in the original precertification.

In any event, we are not sure why it would be limited only to precertifications that have been approved, as opposed to any prospective review that has been approved. We also question whether it should deal with concurrent as well as prospective UR.

Subsection (c): The Bureau should establish a time frame in which it will assign these requests.

Section 127.842 - Requests for UR - redetermination

Subsection (a): Again, this seems limited to prospective UR requests that were denied - whether as prospective UR or precertification requests. That should be clarified.

Subsections (a) and (b): As with our comments on Section 127.833, we are concerned with the reference to "change in the employee's medical condition" - the reference should be to work-related injuries, not any change.

Subsection (c): The reference to addressing "treatment rendered after the initial determination" suggests this could be something other than prospective only - highlighting the need for clarification requested in subsection (a).

Subsection (d): The Bureau should establish a time frame in which it will assign these requests.

URO operations

Section 127.851 - Requesting and providing medical records

Subsection (a): Consistent with the current Section 127.457, this should be five days from receipt of the Notice of Assignment. Further, we note the detailed time frames here, and question why the Bureau does not impose similar time frames on itself.

Section 127.854 - Obtaining medical records - provider under review

Subsection (a): We question whether certified mail is necessary or a cause of needless delay; first class mail, possibly with a proof of mailing, should suffice.

Subsection (b): This requires a provider's "verification". The Bureau should clarify whether this is the same type of verification required of reviewers in Sections 127.867 and 127.1017; if so, the same language and reference to 18 Pa.C.S. Section 4904 should be used.

Section 127.855 - Employee personal statement

Subsection (a): The employee is not qualified to evaluate the reasonableness and necessity of the treatment under review; that is a medical question, and allowing a layman to comment is inconsistent with the URO process. In any event, the employee should have to verify any statement, as required of others in other sections.

Subsection (c): **Subsection (5)** seems to acknowledge the concern we raised with Section 127.805: An insurer requesting a UR might not know all the providers and therefore couldn't identify them.

Section 127.858 - Obtaining medical records - independent medical exams

We question why the Bureau refuses to allow IMEs to be part of the record before a URO. These are a legitimate part of the medical record and should be allowed on all sides; the URO can weigh the value of IMEs, but there is no reason - and no basis in the Act - for their exclusion.

If IMEs are to be excluded, the regulation needs to clarify that the exclusion applies to any reports prepared for an employee that are not the reports of treating physicians. The problem is with a "summarizing report" of an expert who himself is not the treating physician, or whose report summarizes findings of non-treating physicians, getting in.

Section 127.859 - Obtaining medical records - duration of treatment

The URO should obtain these records, not just attempt to obtain them. In any event, it should have to list whatever records it was unable to obtain and the reasons it was unable to obtain them.

Section 127.861 - Provider under review's failure to supply medical records

Subsection (a): This states that a URO must rule against the "provider under review" who fails to supply records. It needs to be reconciled with subsection (b), which has different provisions for providers who fail to provide records. Does that latter subsection relate only to providers not under review?

Subsection (c): The phrase "without reasonable cause or excuse" is an oddity - an invitation for "the dog ate my homework" appeals. It should be deleted. Further, allowing a provider to appeal a URO through a Petition for Review where he is unable to introduce evidence invites a wasteful appeal. This seems inconsistent with the Commonwealth Court's ruling in County of Allegheny v. WCAB (Geisler), 875 A.2d 1222 (2005).

In short, a provider who fails to supply records should not only lose at the URO level, but should be barred from filing an appeal of the URO's decision, not just barred from submitting evidence in that appeal.

Section 127.862 - Requests for UR - deadline for URO determination

Subsection (a): This suggests that a request for UR could be deemed complete even without receipt of all medical records ("or 18 days…"). Absent receipt of medical records, as well as other information required in Section 127.805, no request for UR should be deemed complete.

Subsection (c): This section's 10-day limit for recertifications and redeterminations needs to be reconciled with the timing in Section 127.861; that section gives 15 days to providers being reviewed, without a different limit for recertifications and redeterminations.

Section 127.864 - Duties of reviewers - generally

Subsection (a): What is meant by "the best clinical evidence regarding the treatment"? Who makes that determination? Further, this seems to prohibit consideration of reports and studies submitted under Section 127.856; the two sections need to be reconciled. Further, the regulation should include sanctions for reviewers who do not adhere to whatever provisions are ultimately promulgated, as with a quality assurance intervention; otherwise, the regulation is without teeth.

Subsection (b): The reference to "for the diagnosis of the employee" is confusing. What does this mean?

Section 127.865 - Duties of reviewers - conflict of interest

Generally: These make more sense than the conflict standards set forth in Section 127.808, as they are correctly directed at the reviewer rather than the URO; they should replace, not be in addition to, the standards in that section. **Subsection (4)**, however, may need clarification as to the "party in the matter" - as the URO itself could be considered a party, at least on appeal.

Section 127.867 - duties of reviewers - signature and verification

Subsection (a): This should clarify that electronic signatures may be used.

Subsection (b): Whatever verification standard the Bureau adopts should be consistent as to all those submitting verifications, as noted in Section 127.854(b).

Section 127.869 - Duties of UROs - full report

Subsection (c): As noted earlier, this seems inconsistent with Section 127.811(c), and the two subsections should be reconciled.

Section 127.870 - Form and service of determinations

Subsection (a): Again, the Bureau refers to a form without disclosing it; that form should be disclosed as part of the regulation to allow for meaningful comment on it.

Subsections (c) and (d): These should clarify that copies be served on the requisite parties at the same time.

Section 127.871 - Determination against insurer - payment of medical bills

Generally: We note that determinations against insurers come with penalties, while determinations against providers do not - and that insurers pay for the URO in either event. The Act does not intend such a lop-sided process, and the regulation (and this section) should be revised to be neutral.

Subsection (b): This provides that the insurer pays interest if treatment is "eventually" determined to be reasonable and necessary. That, however, rewards the dilatory provider. This subsection should be revised to toll any interest for periods of time where delay was due to a provider's or employee's failure to comply with this regulation.

UR - Petition for Review

Section 127.903 - Petition for review - notice of assignment and service

As with numerous other sections, the Bureau imposes no time frames on itself. It should.

Section 127.905 - Petition for review - transmission of records

As with numerous other sections, the Bureau imposes no time frames on itself. It should.

Section 127.906 - Petition for review by Bureau - hearing and evidence

Subsection (c): While a judge may not be bound by a URO, he should at least have to give it added weight and deference - and it should not be overturned unless the judge has gathered evidence through his own PRO.

Subsection (d): This should provide that a judge "shall", not "may", disregard evidence in these situations, consistent with common sense and the Commonwealth Court ruling noted in our comments to Sections 127.861.

Peer Review

Section 127.1001 - Peer review - availability

Subsection (a): This should provide that a judge "shall", not "may", obtain an opinion of a PRO in these situations.

Subsection (b): This should provide that a judge "is", not "is not", required to grant a party's motion for peer review - with the exception limited to the second sentence in subsection (a)(2).

Section 127.1002 - Peer review - procedure upon motion of party

Generally: These subsections should be changed consistent with the recommended changes to the discretionary provisions of the preceding section.

Section 127.1003 - Peer review - interlocutory ruling

This should be eliminated consistent with the recommended changes to the preceding two sections.

Section 127.1004 - Peer review - forwarding request to Bureau

As with many other sections, the Bureau refers to a form but does not disclose the form in this regulation. It should. It also imposes no time frames on itself. It should.

Section 127.1005 - Peer review - assignment by Bureau

As with numerous other sections, the Bureau imposes no time frames on itself. It should.

Section 127.1006 - Peer review - reassignment

As with numerous other sections, the Bureau imposes no time frames on itself. It should.

Section 127.1007 - Peer review - conflicts of interest

We have the same concerns here as with Section 127.808 and conflicts of interest in URs.

Section 127.1010 - Obtaining medical records - independent medical exams

We have the same concerns here as with Section 127.858: IMEs should be allowed in the record. Nothing in the Act suggests to the contrary, and allowing them is consistent with the Bureau's statement that rules of evidence shall be broadly construed.

Section 127.1015 - Duties of reviewers - finality of decisions

Subsection (b): This makes no sense and is without statutory authority. If a reviewer is somehow unable to render a decision, the matter should go to a different reviewer.

Section 127.1016 - Duties of reviewers - content of reports

This makes sense, in contrast to the more limiting provisions in Section 127.864. The two sections should be reconciled.

Section 127.1017 - Duties of reviewers - signature and verification

Subsection (a): This should clarify that electronic signatures may be used.

Subsection (b): Whatever verification standard the Bureau adopts should be consistent as to all those submitting verifications, as noted in Section 127.854(b).

Section 127.1022 - PRO reports - evidence

While a judge may not be bound by a PRO report, he should at least have to give it added weight and deference.

URO/PRO Authorization

Section 127.1051 - Authorization of UROs/PROs

Subsection (b): The regulation should require that any RFP by the Bureau require that UROs and PROs accept cost limits on their services. Currently, insurers are faced with review organizations that have no limit on costs, without any redress or ability to hold down or negotiate such costs. Further, the Bureau should require that any offeror submitting a proposal be certified by the American Accreditation Commission (I believe that is the successor to URAC accreditation).

HIPAA non-applicability

We recommend the regulation clarify that HIPAA - or more accurately, the Insurance Department's regulation implementing its privacy provisions - does not apply to workers compensation. Over the years, there has been occasional confusion on this, so clarification here would be helpful and is consistent with an already-existing regulation from another agency.

Concluding thoughts

The length of these comments reflects, to be sure, substantial objections and questions to the proposed regulation.

We believe the Bureau has taken a relatively short and straight-forward part of the Workers' Compensation Act - which sought to contain medical costs by implementing a Medicare-based fee schedule and providing for utilization review - and created an administrative labyrinth that subverts the goal. The regulation does this not just through pronouncements that reduce savings, but through a needlessly complex administrative process to arrive at those savings.

We do not believe these pronouncements have statutory authority - certainly they are not consistent with the purpose of cost containment behind the enactment of the relevant statutory provisions. The irony is that the Bureau has spent considerable time on flawed and confusing - but ultimately expensive - proposals relating to its charge master, its fee review process and its utilization review system; but it continues to leave unaddressed the establishment of a "usual and customary" database, an area that really does need regulation.

At the same time, we hope the Bureau recognizes that the length of these comments demonstrates our commitment to work with it and all other interested parties toward the promulgation of revisions to Chapter 127 that will provide clarity and savings consistent with the Act.

While greater dialogue prior to the submission of these proposed regulations to the IRRC would have helped, we hope that there will be more meaningful dialogue throughout the remainder of the IRRC process, and these comments are submitted in an effort to jump-start that dialogue. The challenges for all parties - the Bureau, insurers, employers, providers and injured workers - can only be met if we work together as partners in fulfilling the promise of the Act.

Sincerely,

Samuel R. Marshall

C: James M. Smith, IRRC
Scott R. Schalles, IRRC

Senate Labor and Industry Committee
House Labor Relations Committee

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President & CEO

September 10, 2004

John T. Kupchinsky, Director
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1171 South Cameron Street
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Re: Chapter 127 - Medical Cost Containment

Dear Director Kupchinsky:

The following are comments from the Insurance Federation and our national counterparts concerning Chapter 127 of the Department's regulations, implementing the medical cost containment provisions of the Workers' Compensation Act. These supplement comments we submitted to the Bureau in a December 2, 2003 letter, a copy of which is attached; both should be considered our formal "written testimony" as requested in your August 25 notice.

We make two general points at the outset. First, there is a growing urgency in all this. Insurers are under considerable demand to hold down workers compensation costs while still providing proper compensation to injured workers and providers treating them. Our efforts to meet this demand are increasingly hampered by the administrative burdens of Chapter 127 - burdens that produce costs that benefit neither injured workers, employers or providers.

We hope the Bureau acts quickly and decisively to reduce these needless costs. In past discussions, the Bureau has noted it is limited by the underlying act. True enough, and we also ask that the Bureau use this exercise to at

least come up with positions on the statutory changes we have requested to reduce these costs. Whether the answer to a particular problem is in changing Chapter 127 or the underlying act - or both - the Bureau needs to be a more vigorous proponent of reform. The issues we are raising in this submission are not new; what is needed is action from the Bureau on them.

Second, the Bureau should be mindful of the general goal of Chapter 127 - and of the provisions of the act it implements - in proposing revisions. The goal - indeed, the title - of the regulation is medical cost containment. All revisions should be measured against that goal.

As to specific sections, we offer the following comments in addition to those in our December 2, 2003 letter.

Subchapter A - Preliminary provisions

Section 127.3 - Definitions

"HCFA:" This should be updated, in the definitions and in the many sections of Chapter 127 referencing it, to CMS (Center for Medicare Services).

"Usual and customary charge:" The definition quotes the act in referring to charges "made by providers of similar training, experience and licensure." In several sections where the phrase is used, however, it is tied to a provider's usual and customary charge - a singular use that conflicts with this definition and the act.

Subchapter B - Fees and fee review calculations

Calculations

Sections 127.101 and 127.102 - Medical fee caps

The first section triggers our concern with the regulations' continued reliance on 1994 Medicare

reimbursement mechanisms, and our request that the Bureau revise this section and all related ones to use current Medicare methodologies.

The second section triggers our request that the Bureau recognize such data bases as Ingenix to allow for a true determination of "usual and customary charges" as called for in the act.

In past discussions, the Bureau has opined that the only possible data bases that would fulfill the "usual and customary" requisites in the act are those of the Blues - and that data simply is not available. We disagree. We believe if the Bureau were to designate a data base such as Ingenix in the regulations, it would be a reasonable means of fulfilling the requisites of the act - especially if approved by the IRRC and the Senate and House standing committees.

We note that the Bureau seems to approach these two sections with contrasting attitudes: With the fee schedule, it labors diligently to maintain a cumbersome administrative system - the chargemaster - contending that it is bound by the act to do so regardless of growing absurdities and inconsistencies in that system. With "usual and customary," however, the Bureau has done nothing to create or authorize a data base, leaving that portion of the act inexcusably unfulfilled.

The only similarity in these approaches is the impact of increasing medical costs - precisely the impact both the act and Chapter 127 when first promulgated intended to stop.

Section 127.109 - Supplies and services not covered by fee schedule

The reference to a provider's usual and customary charge should be reconciled with the definition of "usual and customary charge" in Section 127.103 and in the act. The focus is on similar providers, not the provider submitting the bill.

Section 127.128 - Trauma centers

Again, the problem is that the act and the regulations define "usual and customary charge" in terms of similar providers, not the one submitting the bill - but this section speaks only of the trauma center, not similar ones. Notably, this is one instance where the Bureau itself could develop a data base to determine usual and customary charges as defined in the act and regulations, since the Bureau presumably has the needed data through information submitted to it in developing its chargemaster.

Section 127.129 - Out-of-state medical treatment

Subsection (b): While we support the sentiment in this subsection, we note it is unenforceable as to other jurisdictions. It is of some help in arguing with out-of-state providers, but not in enforcing matters against them.

Section 127.130 - Special reports

Subsection (b): Again, the problem is that the act and the regulations define "usual and customary charge" in terms of similar providers, not the one submitting the bill - but this section speaks only of the provider, not similar ones.

Insurers have noted abuses in this area, with considerable excess billing by treating physicians - including billing separate special reports for each potential job at full rates, even where the reports are veritably identical. But with little control over "usual and customary" standards, those abuses are difficult to correct.

Section 127.131 - Payments for prescription drugs and pharmaceuticals

Pharmacists routinely ignore this section, forcing injured workers to pay more than 110% of the AWP of the product. We recognize the Bureau's limited enforcement power over pharmacists. That could be corrected by revising this

regulation to provide that the Bureau shall investigate such instances and refer them to the appropriate licensing boards and the Attorney General for enforcement proceedings.

Section 127.132 - Payments for prescription drugs and pharmaceuticals - direct payment

This may be as much a question as a recommendation, but the Bureau should explore allowing insurers to include pharmacists as part of any designated list of providers in Subchapter D, and should explore means of doing so that might be different than used for other providers.

Further, as a clarification, we recommend the last sentence of subsection (b) clarify that insurers need not make such a prescription program available to all claimants.

Medical Fee Updates

Section 127.153 - Medical fee updates on and after January 1, 1995

Subsection (c): This is where compliance gets costly and cumbersome for insurers and, we suspect, for the Bureau, with all the new codes and changing multipliers. This is the type of cost the Bureau's revisions should eliminate, not perpetuate.

We have always emphasized the cost on insurers. It would help for better public discussion of this issue if the Bureau would set forth its own costs in implementing and operating the chargemaster, both with respect to Bureau employees and outside vendors.

Billing Transactions

We emphasize our earlier recommendation that the Bureau provide a deadline on providers for submitting bills, and we propose it be 60 days from the date of treatment absent

explanation. It will help combat fraud; it will also reduce administrative costs, as it is easier to evaluate and process "fresh" bills than old ones.

Section 127.210 - Medical bills - standard forms

Subsection (a): This is another section where the reference should now be to CMS, not HCFA. Further, we note the ongoing complaints, albeit without details, of insurers being late in paying providers' bills. Some alleged delays may be attributable to a number of providers not using the forms required by this section.

We are sensitive to the allegations of late payments from segments of the provider community and hope the Bureau's review provides more specificity of the problem areas.

One observation that may help expedite payments, or at least reduce questions on potential code manipulations by providers: Insurers note a concern that some providers may engage in code manipulation to fall outset the fee schedule, on the belief that the lack of meaningful "usual and customary" standards may lead to higher reimbursements. A "usual and customary" data base may help solve this problem.

Further, a number of insurers have begun to accept electronic billing. This is an option that should be encouraged as a means of expediting payments.

Section 127.205 - Calculation of amounts of payment due to providers

We note that insurers are the ones obligated to calculate the proper amount of payment, meaning we are the ones absorbing the bulk of the administrative and processing costs.

Perhaps that explains the provider community's general inertia and resistance to changing the chargemaster: It imposes no burdens on them. But the reality is that the

administrative cost of calculating payments is considerable under these regulations, largely because of the fee schedule's reliance on 1994 Medicare methodologies, and the further reality is that everybody ultimately pays that cost.

We understand that those not directly impact by a problem have limited incentive to see it fixed - but they should not be allowed to block or delay efforts to fix the problem, either.

Sections 127.206 - Payment of medical bills - request for additional information

This section should expressly provide that when additional records are needed from providers, so is additional time under Section 127.208, with no penalty.

Review of Medical Fee Disputes

Section 127.253 - Application for fee review - documents required generally

We recommend adding the LIBC-9 as a required document. Further, this is another section needing the editorial of CMS rather than HCFA.

Subchapter C - Medical Treatment Review

UR - General Requirements

Along with updating the Medicare reimbursement mechanisms and designating a data base for usual and customary charges, this is our third general area of concern: Under the current regulations, utilization review has become increasingly ineffective in identifying and preventing excess utilization.

We appreciate that the Bureau has been in the process of revising this subchapter, and it would help all interested

parties if the Bureau would share a draft to serve as the foundation for comments, or at least the ideas it is considering. That would at least give interested parties some idea of the problems the Bureau see with utilization review, and the solution it believes it has the power to implement by regulation.

As noted in our December 2, 2003 letter, a major problem with UROs is that workers compensation judges often simply ignore or discredit them. Some of that may be solved by changing the URO process, in the hope that it will address judges' concerns with UROs themselves.

For instance, the regulations should specifically allow for insurers to send in all records, including Independent Medical Exams, and for the URO to consider all relevant medical records related to the patient, not just the particular provider being reviewed. That would mean deletion of Section 127.461 - which we strongly recommend.

Thank you for the opportunity to comment on this. Again, we reiterate the urgency to address Chapter 127, in particular its provisions on the 1994 Medicare methods, the lack of a meaningful "usual and customary charge" standard and the utilization review provisions. Doing so is essential if the Bureau, and insurers, are to fulfill the legislative intent of the act - that there be meaningful medical cost containment.

Sincerely,

Samuel R. Marshall

Original: 2542

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Samuel R. Marshall
President & CEO

December 2, 2003

Eileen Wunsch, Chief
Health Care Services Review Division
Bureau of Workers' Compensation
Department of Labor and Industry
1171 South Cameron Street
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Re: Chapter 127 - Medical Cost Containment

Dear Ms. Wunsch:

We appreciate the Bureau's recognition that this chapter, implementing the medical cost containment provisions in Acts 44 and 57, is sorely in need of modernization. The following are our suggested revisions to achieve this.

Subchapter A - Preliminary provisions

Section 127.3 - Definitions

"Actual charge:" The problem is the lack of a "usual and customary" data base acceptable to the Bureau. While the Blues have one, they will not share it for proprietary reasons, and you have been reluctant to accept any other because of a concern of judicial acceptance. We believe a national data base - such as that of Ingenix - would work. Perhaps this definition could expressly refer to any Pennsylvania-based or nationally recognized data base approved by the Bureau.

Subchapter B - Fees and fee review calculations

Section 127.101 - Medical fee caps - Medicare

Subsection (d): You know our basic concern here, and it is the dominant ones with these regulations. We are saddled with 1994 Medicare reimbursement mechanisms that are not just outdated, but increasingly impossible and unreasonable to use.

Only Pennsylvania workers compensation still relies on the Medicare reimbursement mechanisms required by this regulation. Nobody else in Pennsylvania or across the country uses this. That makes understanding and administering these mechanisms not just impossible and unreasonable, but expensive - and not just for insurers and self-insured employers, but for providers and the Bureau. The cost is administrative, with no benefit to injured workers either in benefits or ensuring access to quality care. The wasted administrative cost is borne by insurers and employers.

The only beneficiaries are pockets of providers for whom these outdated Medicare mechanisms produce somewhat (and randomly) higher reimbursement levels than do current mechanisms. We do not believe such random rewards were the intent of the acts, and they should not be furthered by this regulation.

Accordingly, we renew our request that the Bureau revise this section (and the others tied to it) to use current Medicare methodologies. In the past, the Bureau (or at least the Department) supported legislation doing this, but has felt a regulation doing so would be inconsistent with current law. We also ask that you revisit this position: A regulation should make a statute capable of reasonable implementation, not perpetuate an impossible, unreasonable and increasingly absurd standard that benefits nobody.

Section 127.102 - Medical fee caps - usual and customary charge

This goes back to our comment with the definition of "actual charge:" The Bureau needs to specifically recognize such data bases as Ingenix. Otherwise, as happens now, this section is meaningless, at least to the extend the Bureau does not recognize any broad data base for calculating usual and customary charges.

Section 127.103 - Outpatient providers

Subsection (c): We have the same comment as in the previous section.

Section 127.111 - Inpatient acute care providers - DRG payments

The Hospital Association may comment that this should be revised to modernize DRG groupers. To some extent, we understand that concern - but any modernization of this should only occur if and when the Medicare reimbursement mechanisms themselves are updated.

Sections 127.117 through 127.120, 127.122, 127.123 and 127.125 - Medicare reimbursement mechanisms

These sections refer to outdated Medicare forms and mechanisms and highlight the need to revise these regulations to incorporate current Medicare reimbursement mechanisms.

They also highlight the problem of new providers not getting into the system. Continuing a system that is excessively difficult for providers to join, as well as for insurers, providers and the Bureau to implement - is certainly not what the General Assembly intended in enacting the underlying legislation.

Section 127.125 - ASCs

We frequently encounter attempts by providers to bill for separately for supply items that should be within a covered procedure. This is something of an unbundling concern, with the added dimension that providers may be using this approach to circumvent the fee schedule and default to the "80% of usual and customary" rate - with the problem of a lack of a schedule for that rate noted above.

Section 127.126 - New providers

We note the difficulty of entering some new providers into the chargemaster because of a lack of data and other necessary information - which goes, again, to the need for the Bureau and all interested parties to come up wit a workable alternative to that. Subsection (c) highlights this problem: Our understanding is that Medicare no longer uses the audited reports and NPRs referenced therein.

Section 127.127 - Mergers and acquisitions

We have the same problem - applying outdated Medicare rules to current mergers and acquisitions - as with the preceding section. Again, we recommend the same solution - getting rid of the outdated chargemaster approach.

Section 127.131 - Payments for prescription drugs and pharmaceuticals

We note the ongoing problem of pharmacies requiring injured workers to pay retail despite the prohibitions here, with the lack of any regulatory enforcement from the Bureau. For instance, much as we may agree with subsection (c), what power does the Bureau have to enforce it?

This is also a good opportunity to consider a generic drug mandate, as in many other states, possibly as a fee schedule cap.

Medical Fee Updates

Section 127.154 - Medical fee updates - inpatient providers subject to DRGs

As with Section 127.111, we appreciate the Hospital Association may comment that this should be revised to modernize DRG groupers. As noted above, we believe any modernization be more full-scale, meaning an updating of all Medicare reimbursement methodologies.

Section 127.155 - Medical fee updates - outpatient and other cost-reimbursed providers

We note fewer problems with providers not updating their chargemaster information, which I guess is progress of sorts; still, some penalty provisions should be considered.

We should consider changes to subsections (d) and (e), as they call for changes based on Medicare rules that are no longer in place or available.

Section 127.162 - Medical fee updates - new allowances

I am not sure how many new allowances the Commissioner has adopted. But this section again highlights the need to include new Medicare methodologies within the parameters of allowances.

Billing Transactions

As a general comment, the focus here is on the time in which insurers have to pay bills. Missing is any focus on the time in which providers have to submit bills from when the service is rendered. We recommend the Bureau propose, either by revising this regulation or by legislation, a rule on that, as with a similar measure in New York. A time bar for submitting bills will greatly help in combating fraud. It shouldn't be objectionable to providers, especially if penalties match those on insurers who themselves exceed the 30 day limit in Section 127.208.

Section 127.203 - Medical bills - submission of reports

This would be the appropriate section in which to include a requirement that provider submit bills within a certain period after providing treatment. If a provider can be required to submit medical reports within a set time, it only makes sense that he be required to submit related bills.

Section 127.207 - Downcoding by insurers

We recommend this section be revised to expedite any disputes that occur in a downcoding of a provider's codes, and to reconcile the time constraints here with those in Section 127.208. Our general experience is the process set forth in this section takes a needlessly long time and runs up against the 30 day rule in Section 127.208, especially if the provider is not prompt in his response.

A possible revision would be to change this section to provide that insurers pay the bill as downcoded, with the explanation of the downcoding in the EOB, with any disputes treated as after-payment disputes to be resolved through the fee review process.

Section 127.208 - Time for payment of medical bills

The three days in subsection (b) are inadequate: The mail isn't always that fast, and the timing starts on the faulty (or inadequate) premise that the date of mailing is the date on the bill (as opposed to the date of actual mailing). This section should at least allow for an exception where the insurer has a routine procedure of date stamping any and all bills submitted - with that date serving as the date of submission.

Review of Medical Fee Disputes

Section 127.252 - Application for fee review

All sides may want to consider issues related to resubmissions by providers. My own information is somewhat sketchy on this, and we will follow up with more on this.

Subchapter C - Medical Treatment Review

UR - General Requirements

We understand the Bureau is preparing a general reworking of this area, which we believe is necessary. We recommend you consider the following:

- The appeals process is particularly troublesome, as many workers compensation judges do not give any deference to the findings of the URO consistent with the de novo language in Section 127.556. We recommend the URO's findings be given a presumption of validity on appeal, perhaps provided the URO satisfies URAC standards or in the absence of any evidence to the contrary.

- The cost of the URO can, on occasion, be excessive without any recourse for the insurer stuck with the bill. We need the Bureau to be more aggressive in policing this, perhaps through its certification process or by allowing insurers to pay no more than the usual and customary rate for a URO. This is something that could be addressed within Section 127.652 setting forth standards in applications for UROs.

Peer Review

Our experience is that workers compensation judges never use this. Perhaps this could be revitalized in conjunction with our concern about de novo reviews in Section 127.556: For instance, the Bureau could provide that a judge can overturn a URO only if his determination is supported by the findings of a PRO.

Subchapter D - Employer List of Designated Providers

The main problem with this subchapter is the excessive notice requirements in Section 127.755. We recommend this section be revised to provide that an employer cannot direct an injured worker to a designated provider unless and until proper notice is provided.

We have a final comment, one pertaining to the Bureau's December 13, 2002 Statement of Policy to hospitals instructing that they convert to CPT and HCPCS by June 30, 2004.

We are not sure why the Bureau believes it is empowered to do this by Statement of Policy, thereby avoiding input from affected parties or regulatory scrutiny, whereas changes we

have recommended always seem to fall into the "it'll take a regulation or legislation" holding bin. We also believe this change will lead to still higher provider reimbursements and should not be made absent a change to current Medicare methodologies; it seems inconsistent to do one without the other.

Thank you for taking on the task of revisiting and revising Chapter 127. Medical cost containment was a cornerstone of Acts 44 and 57, and one that needs to be maintained. The best way to do that is by modernizing the Medicare methodologies, and we hope to work with the Bureau and the department in this regard, as well as in addressing the other concerns noted herein.

Sincerely,

Samuel R. Marshall

C: Elizabeth A. Crum, Deputy Secretary
Office of Compensation and Insurance

John Kupchinsky, Director
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