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Pennsylvania Medical Society®

July 10, 2006

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

Re: Chapter 127 Regulations-Comments

Dear Ms. Wunsch:

Please accept the attached comments submitted on behalf of the Pennsylvania Medical Society related to the above-captioned proposed rulemaking. The Medical Society appreciates the effort the Bureau has put forth in the drafting of the regulations and in responding to the varied concerns of the provider and insurer communities. Our specific comments are separated by subsection.

The Medical Society looks forward to participating in the process as the regulations move forward. The Society will be happy to provide technical assistance to the Bureau as to how the Medicare process functions and the practical application of the proposed changes in actual practice settings.

Sincerely,

Mark A. Piasio, MD
President

CC: Independent Regulatory Review Commission
Chairs, Senate Labor and Industry Committee
Chairs, House Labor Relations Committee

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Comments on Proposed Workers' Compensation Regulations

§ 127.3 Definitions

Class A ASCs are not licensed by the Department of Health, but must register with the Department. Therefore the definition of an ASC should be amended to state:

> *ASC--Ambulatory Surgery Center*--A center that operates exclusively for the purpose of furnishing outpatient surgical services to patients**[. These facilities are] that is** referred to by **[HCFA] CMS** as **[ASCs] an ASC** and **is licensed, registered, or otherwise approved** by the Department of Health as **[ASFs] an ASF. [For consistency with the application of Medicare regulations, these facilities are referred to in this chapter as ASCs.]**

The definition of medical records should be amended to include language stating that the release of medical information is limited to the medical information minimally necessary and authorized under the workers' compensation statute. Any medical treatment information not related to the treatment of the work injury requires a patient authorization or a court order.

The definitions of Medical Reports and the Medical Report Form are unnecessarily confusing. The current Medical Report Form (the LIBC-9) provides space for the information required in the definition of Medical Report.

"Usual and customary charge" databases are often not reliable, as they do not typically provide a good cross-section of charges. The Medical Society would like more detail on the Bureau's criteria for an authorized database and recommends using the 75th percentile of any approved database.

§ 127.101 Medical fee caps – Medicare

The Medical Society recommends that Section 127.101 Medical fee caps – Medicare subsection (f) be amended to read, "(f) An insurer may not make payment in excess of or less than the medical fee caps,…" This language would address the number of PPOs who are discounting physician workers' compensation payments because the physician has a health insurance contract with the insurer.

§ 127.201 Medical bills – standard forms

The Medical Society understands the insurance carriers desire to implement a restricted billing period, however the 90 day billing requirement under Subsection (c) needs to be expanded to at least 180 days, which is the standard in the health insurance industry.

Also, there needs to be an exception for the patient who fails to advise the provider that the injury occurred at work, such as a provision that would allow the physician to directly bill a patient after the 180-day period. Consider these scenarios: (1) the patient is afraid they will lose their job if they file a claim and do not notify the provider for several months; (2) the employer has a designated list of providers and the patient goes to a non-designated provider and fails to notify the provider; or (3) the patient wants to go to a provider of their choice and initially wishes to pay out of pocket, until they get the bill. There have been a couple of cases where a provider has billed private insurance, sometimes up to two years, then receives a letter from an attorney stating that the patient has now filed a workers' compensation claim. If the patient is faced with paying the bill directly, they may be more upfront in disclosing the nature of their injury.

Several providers have complained that it is difficult to get insurance billing information from the employer or the employer has changed insurance carriers and there is a dispute as to payment responsibility. In any event, there needs to be a mechanism to resolve these issues other than punishing the provider.

§ 127.203 Medical bills – submission of medical reports

Subsection (a) refers to the submission of the Medical Report commencing 10 days after initial treatment. Assuming the Medical Report is the current LIBC-9 form, what is the Medical Report Form referred to in (c), "Providers shall submit the Medical Reports required by subsection (a) with the Medical Report Form"? It is unnecessarily confusing to refer to them as separate items. Also, the release of medical information to an insurer must be limited to the medical information minimally necessary and authorized under the workers' compensation statute. Any medical treatment information not related to the treatment of the work injury requires a patient authorization or a court order.

§ 127.209 Explanation of reimbursement paid

The Medical Society supports the Bureau's language on the Explanation of Reimbursement (EOR) in subsection (b) (1) through (6). The regulating of the language will help ease the difficulty some providers experience in interpreting the creative terminology utilized by certain insurance carriers.

§ 127.256 Administrative decision and order on an application for fee review

The Medical Society would like to see the 30-day timeline for administrative decisions restored. The Society understands that the actual timeframe has not been met for many years, however to remove the timeframe entirely is not practical. There needs to be some accountability.

§ 127.260 Fee review adjudications

The Medical Society would like to see the 90-day timeline for fee review adjudications restored. Again, the Society is aware that the 90-day timeline has not been met for years, however, there needs to be a timeframe established.

§ 127.751 Employer's option to establish a list of designated providers

Subsection (g) should allow for the patient to seek a second opinion from another provider regardless of whether the designated provider prescribes invasive surgery. Maybe the designated provider doesn't prescribe surgery, but the employee wants to explore their options. The Medical Society suggests the following language, "If a designated provider prescribes a specific course of treatment for the employee, the employee may seek an additional opinion from any healthcare provider of the employee's choice."

§ 127.851 Requesting and providing medical records

Subsection (b) should be amended to read as follows: "(b) Within 5 days of the date of the Notice of Assignment, the URO shall request that the provider under review provide a complete set of records relating to the ***treatment of the*** work injury. The URO shall submit the request to the provider by certified mail."

The timeframe of 7 days for responding to and mailing the medical records to the URO is too short. The Medical Society would like to expand the timeframe to 15 days.

Again, the Society would like to see language stating the release of medical information be limited to the medical information minimally necessary and authorized under the workers' compensation statute. Any medical treatment information not related to the treatment of the work injury requires a patient authorization or a court order.

§ 127.854 Obtaining medical records – under review

Subsection (b) "When records are not accompanied by the appropriate verification, the URO shall return the records to the provider, may not consider the records in issuing its determination, and shall disregard the fact that the records were forwarded to the URO." This is an extremely harsh and unnecessary penalty. The Medical Society recommends that the verification documentation language be eliminated. Providers should not have to hire a legal team in order to provide workers compensation services.

§ 127.855 Employee personal statement

The Medical Society agrees that the employee should be allowed to submit a statement regarding the reasonableness and necessity of the treatment under review. However, the employee should be allowed to provide any enclosures, attachments, or documentation the patient feels necessary to support their case. Also, the patient should be able to refer to any independent medical exam or impairment rating they have undergone.

§127.857 Obtaining medical records – other treating providers

Medical record confidentiality and the providing of treatment records for workers compensation injuries must be established. Providers are permitted to provide medical records as directed by the workers' compensation law, however any additional information regarding the patient that is not related to the treatment of the injury requires patient authorization or a court order. Physicians who disclose medical treatment information that is not related to the treatment of the work injury may be subject to state and federal disciplinary action. Therefore, it must be clearly articulated throughout these regulations that any request for medical treatment information must be specific and limited to those portions of the record that are minimally necessary in the absence of a patient authorization or court order permitting a broader release.

§127.460 Obtaining medical records – other treating providers

Again, the Medical Society feels that the language in subsection (b), "When records are not accompanied by the appropriate verification, the URO shall disregard the records and return the records to the provider" should be removed as unduly harsh.

Duties of reviewers – consultation with provider under review

The Medical Society is concerned that the language providing for the URO review to consult with the physician providing treatment has been removed and recommends that the language be restored in its entirety from § 127.469 of the current regulations.

Record retention requirements for UROs

The Medical Society would like to see the current regulatory record retention requirements for UROs to remain in the proposed regulations.

§ 127.903 Petition for review by Bureau – time for filing

The Medical Society requests clarification as to how many copies of the petition for review are required under this subsection.

§127.1004 Peer review – forwarding request to Bureau

Subsection (b) needs to be specific in that, absent a patient's authorization or court order, the medical records to be subpoenaed are limited to only those medical records authorized under the Workers' Compensation law.

Duties of reviewers – consultation with provider under review

The Medical Society is concerned that the peer review organization (PRO) is not allowed the opportunity to discuss the treatment of the work related injury with the provider. This section should be restored (current regulation § 127.616).

Record retention requirements for PROs

The Medical Society is concerned that the record retention requirements for PROs have been removed and would like to see them reinstated.

UR Pre-certification

The Medical Society agrees that there should be a pre-certification process available to employees and physicians to utilize, however there needs to be a timeline for pre-certification, such as 30 days from receipt of the treatment plan, and a provision for expedited review in cases where treatment is needed promptly. There must be a provision to ensure that the process is not used to unnecessarily delay appropriate treatment.

Notice of Compensation Payable

The Medical Society would like treating physicians to receive a copy of the Notice of Compensation Payable for workers' compensation patients. The Society is aware of the concerns the Bureau has expressed in the past regarding patient income information on the form, however it is possible for this information to be redacted on the form the Bureau is currently using. Insurers could provider a copy of the NCP upon receipt of the provider's first bill/report or when otherwise notified of the identity of a treating provider.