Original: 2542

RECEIVED
2006 JUL 17 AM 7:14
INDEPENDENT REGULATORY
REVIEW COMMISSION

REMED™
Brain Injury Rehabilitation

July 10, 2006

Ms. Eileen K. Wunsch
Chief, Health Care Services Review Division
PA Bureau of Workers' Compensation
PO Box 15121
Harrisburg, PA 17105-5121

Dear Ms. Wunsch:

Thank you for allowing us the opportunity to provide our thoughts on the proposed revisions to the workers compensation regulations.

1. Requirement to Submit Invoices Within 90 Days

As a hard and fast rule, this requirement poses problems for providers that would result in certain employees not receiving services, or not receiving services timely. While not commonplace, we do encounter cases where the responsible party is unclear. We generally work with the employee and their funders to determine whether auto, health or workers' compensation insurance is the responsible party. This can take greater than 90 days on occasion.

It is also possible that treatment for a client may start and not be complete within 90 days where the treatment is billed based on the course of treatment and not individual dates of service (e.g., a work study evaluation).

We recommend that the Department include the possibility of an extension of time due to extenuating circumstances as long as this is communicated in writing by the provider to the insurer in advance. We further recommend an appeal process to the Bureau in cases where the provider is denied payment by the insurer due to failure to timely file. The provider would be required to demonstrate to the insurer and the Bureau that it has exercised good faith efforts to determine the responsible party and to bill as soon as practicable.

2. Definition of Health Care Provider

The definition of a health care provider in the current regulations was not revised by the proposed changes. It currently is:

> Health care provider means any person, corporation, facility or institution licensed or otherwise authorized by the Commonwealth to provide health care services, including but not limited to, any physician, coordinated care organization, hospital, health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, psychologist, chiropractor or pharmacist and an officer, employee or agent of such person acting in the course of scope of employment or agency related to health care services.

While this definition appears sufficiently broad to include a facility such as ReMed (accredited by the Commission for the Accreditation of Rehabilitation Facilities (CARF), a provider to the Department of Health's Head Injury Program and to the Office of Vocational Rehabilitation), the Bureau has informed us that we are NOT considered a health care provider as currently defined, and were therefore not eligible to request a fee review.

We recommend that the definition be revised to specifically include rehabilitation facilities such as ReMed or that the Bureau broaden its narrow interpretation of the existing definition.

3. Pre-certification Process

We applaud the Department on the addition of the pre-certification process. While this may delay services to certain employees during the time the pre-certification is completed, for others it will ensure services are provided where otherwise providers, with no guarantee of payment, may have not admitted an employee into treatment.

In reviewing the provisions of the revised regulations on the pre-certification process, we attempted to diagram the decision process and found numerous instances where answers were unclear or not apparent. For example, if treatment is pre-certified, may the insurer request a UR after treatment has been rendered? This is not specifically stated in the regulations.

Similarly, if an insurer agrees to pay for services (Section 127.8232 (2) (b)), the Bureau will not process a request for pre-certification. As such, has the insurer then been precluded from requesting a UR after treatment has been rendered? Along those same lines, if the insurer refuses to pay but does not provide the reason(s) therefor, can the insurer request a UR after treatment has been rendered?

We recommend the Bureau review this section, diagramming all of the possible avenues and outcomes if care is/is not pre-certified to ensure that these questions and others are clear in the revised regulations.

4. Provider Under Review's Failure to Supply Medical Records

In Section 127.861, the regulations indicate that if a provider fails to supply medical records to the URO, the URO shall render a determination that the treatment under review is unreasonable and unnecessary. This Section continues on to indicate that the "provider that fails, without reasonable cause or excuse, to supply records under this section may not introduce evidence regarding the reasonableness and necessity of treatment in an appeal.."

In the public hearings today, we heard from a number of UROs who expressed concern about the difficulty in obtaining records due to the insurers providing them with incorrect addresses. Granting a summary judgment from the URO in favor of the insurer in a case where the provider has not been reached via mail would seem to encourage insurers to give UROs bad addresses, and would certainly not be in the best interest of the injured employee.

We recommend that at a minimum, the invoice and medical record required by the regulations to be submitted with the invoice from the provider to the insurer be provided to the URO by the insurer. In addition, we recommend that the Bureau add the requirement that the medical report submitted with the invoice include the address to which requests for medical records should be sent. This would ensure that the UROs would receive documentation from the provider, albeit indirectly, of the correct address to use for medical records requests.

Thank you for the opportunity to provide comments on the proposed changes to the regulations.

Sincerely,

Carla A. Washinko

Carla A. Washinko
Chief Financial Officer