COMPSERVICES, INC.

1717 ARCH STREET ■ 45th FLOOR ■ PHILADELPHIA ■ PA 19103 PHONE: (215) 587-1985 ■ FAX: (215) 587-1826

ORIGINAL: 2542

John J. Madigan
Director of Provider Relations

Second Review

127.201 - The provider, must be paid by statue within 30 days of receipt of the bill. The hospital and medical associations have both requested additional time, citing problems with identifying the employer and/or insurer. CSI believes that 90 days is more than sufficient and strongly recommends that the time frame remains as written.

127.211 - Many employers/insurers use outside bill payment organizations who may not be able to generate or EOR to deny payment on a denied claim. To relieve the economic burden of software rewrites a written denial on any type of denied case should be permitted.

D - A review of section 435 of the act grants broad powers of regulations to the department as noted in (a) through (e). However, this section when written did not contemplate the change and modification of the EOB to EOR. Further, D, as written, in consideration of current workers compensation claims/ legal practices, regarding the filing of penalty petitions, opens a new avenue for the filing of penalty petitions for ANY mistake in preparing an EOR.

127.752 - (b) and (e) CSI's previous statements remain. In addition, these new regulations conflict with Section 306 (f.1) (1) (iii), which clearly permits "coordination of services". Case managers and adjusters are "a single point of contact" and our phone number is listed on the bottom of our employers' provider list. Could these additions, as written, lead to litigation concerning the involvement of adjusters and case managers?

127.801 to 127.1016 - CSI's previous statements remain. We made comments that parts of the new rules and regulations are well written, when considered individually. When considered collectively they become repetitious, complex and confusing. Adding Pre-certification, Recertification and Redetermination have confused the concept of Utilization Review. It is CSI's view that, while there may be some merit to their use, they should be part of the core process of UR; Prospective, Concurrent and Retrospective. Throughout the Medical Treatment Review section there is a great deal of repetition which could be combined. The confusion and complexity of this section is a detriment to the appropriate use of UR.

127.1051 - CSI believes that the cost of UR's is excessive and a deterrent to the use of UR. Cost need to be covered in the RFP. We also suggest that there be some form of "credentialing: of the reviewer, to help ensure quality.

Gelnett, Wanda B.

From: Wunsch, Eileen [ewunsch@state.pa.us]
Sent: Thursday, June 29, 2006 7:36 AM
To: Henneman, Karla
Cc: Kupchinsky, John; Howell, Thomas P. (GC-LI); Kuzma, Thomas J. (GC-LI)
Subject: FW:

KARLA,

This gets printed and logged in. Thanks.

Eileen K. Wunsch, MS, CPIW, ARM
Chief, Health Care Services Review
Bureau of Workers Compensation
Department of Labor & Industry
1171 South Cameron Street
Harrisburg, PA 17104
Phone: 717 772-1912
FAX: 717 772-1919
ewunsch@state.pa.us

-----Original Message-----
From: Hawkins, Krish [mailto:Krish.Hawkins@compservicesinc.com]
Sent: Wednesday, June 28, 2006 4:41 PM
To: 'Wunsch, Eileen'
Subject:

Krish Hawkins
Provider Relations
CompServices, Inc.
1717 Arch Street, 45th Floor
Philadelphia, PA 19103
(215) 587-1997
(215) 561-1826 Fax
krish.hawkins@compservicesinc.com

*** SECUREMAIL ***

COMPSERVICES, INC.

1717 ARCH STREET ■ 45th FLOOR ■ PHILADELPHIA ■ PA 19103 PHONE: (215) 587-1985 ■ FAX: (215) 587-1826

John J. Madigan
Director of Provider Relations

New Reg's Review

127.3 - Definitions

CMS, CCI, DME and Down code in particular are written well.

EOR: This needs a more detailed explanation.

Medical Reports: The definition leaves out any reference to a most important part of workers' compensation, return to work which should be there. After "rendered" should be: return to work decisions. (Note this is referred to as a requirement under 127.203)

Notification of Disputed Treatment: Because of the tactics of certain medical providers in the fee review/ medical litigation and their interpretation of the regulations, this needs to be clarified and probably expanded so that the technical use or non use of specific language will not allow "technical language decisions".

Provider under review; This was well written.

Treatment: The phase; "and facilitating a return to work", should be added (see also Medical Reports and 127.203.)

Medical Fees and Fee Review Calculations

127.111 - *a* through *g* is well written
127.117 - *b* through *h* is well written
127.129 - Removed a paragraph.
127.131 - Was paragraph *b* removed?
127.134 - Item *b* would seem to cancel out *a*.

Billing Transactions

127.201 - *C* limits billing submission to 90 days from first date of treatment on the

bill.
- *D* states if not submitted on time no payment, which is excellent.
- *E* limits scope of practice or licensure, which is good.

127.203 - Well written, does mention return to work.

127.204 - Nice definition; the change to CCI.

127.209 - Change to EOR from EOB
- Good change in language, the use of codes, and the six (6) specific reasons for denial.
- *C* makes mandatory certain wording for the EOR and adds the name of the insurer and Bureau code, all of which are good.

127.210 - Establishes requirements and time frames for paying interest, which were needed.

127.211 - Sets good parameters for the provider about balance billing, but requires an EOR to deny. This regulation should be modified to include a "written denial".
- *D* should be removed; it is punative in nature against the insurer and would be a causative factor in increased penalty petitions and litigation.

Review of Medical Fee Disputes

127.252 - The provider should be required to submit the Bureau Code and insurer name on his application.
- *C* is good because it defines proof of service requirements.
- *D* is good because it gives the Bureau the authority to return bad applications.

127.258 - This is good as it clearly establishes procedure.

D Employer list of Designated Providers

127.751 - This section just cleans up language.

127.752 - The statements in (*b*) and (*c*) regarding single point contact are an unnecessary regulation and have no basis from the statute. Further "single point of contact" is a vague statement in this context. It is not defined under definitions and will cerate confusion on the part of the injured worker, employer and provider.

Medical Treatment Review

127.801 – OK

127.802 – OK

127.803 – OK

127.804 – OK

127.805 – OK

127.805a – OK

127.806 – OK

127.807 – OK

127.808 - Well written.

127.809 – OK

127.810 – OK

127.811 – Excellent as written, now allows entire course of treatment.

Precertification

127.821 - Why is this entire section needed? Are we missing something? With slight modification, incorporating the precertification process into prospective review can be accomplished. As used in this context, we are utilizing what is essentially an insurer's process and are trying to re-engineer it for the patient (claimant) and provider. We believe it will confuse the UR process and produce additional complexity in what is already a complex process.

127.831 - Prospective, Concurrent and Retrospective UR
In reviewing this section and all other UR, sections there appears to be a complexity that confuses. This indicates that close editing of the document, by a select committee, is necessary. As compared to the current regulations the new regulations (which admittingly cover three (3) new sections) are more complex, redundant and not easily understood or followed.

URO Operation

127.852 - (a) through (c) and (1) through (7) present a dilemma for the reviewer. While we agree the reviewer should not decide or "discuss" these points in his review, it may be necessary to " comment upon" as support for a decision on reasonableness and necessity.

127.855 - This section is well written.

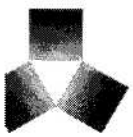
127.856 - This is a nice addition if the insurer's use it.

127.858 - It is fair to rule out IMEs.

127.859 - Very important to review all the medical care

127.861 - (c) is a welcome addition and prevents going around the UR regulations.

127.864 - (See the comments made under 127.852) (c) under this section does seem to try to answer the questions posed under 127.852, however it doesn't go far enough.



- (d) the reviewer should be allowed/ required to name the other courses of treatment.

127.865 - (3) should be modified to include identifying the relevant sections of the "literature" used to support the reviewer's decision. Copies of the relevant "literature" should be attached.

127.870 - (d) Does this really belong in this section as written?
Why is the URO doing this isn't it a decision by the affected parties?
Doesn't this belong under 127.901?

127.906 - (d) this section fails to back up section 127.861 (c)
As it is written it allows the judge to decide if he will allow records in.
This needs a rewrite.

127.1011 - Shouldn't there be an addition to this section that requires the judge to make a decision against the provider not supplying the records?

127.1015 - The same recommendations made for the UR reviewer also hold true here for these 2 sections.

127.1016 -

127.1051 - This is an excellent addition to the regulations, however also must deal with the cost of the review. It is recommended that ranges of fees be established according to the degree of difficulty of the review.

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John J. Madigan
Director of Provider Relations

MEMORANDUM

TO: **Don Liskay**
Vice President of Operations

FROM: **John Madigan**
Director, Provider Relations

DATE: **June 28, 2006**

RE: New Cost Containment Regulations

Don,

Attached is my review, comments and recommendations of the proposed regulations. It is best to review them with the new regulations at hand and the old regulations available as a reference. If I felt a section was fine, for the most part I made no comment.
In general I found them to be well written, with the exception of the Medical Treatment Review section. This section, which added Precertification, Recertification and Redetermination while well written is complex and confusing. This is an important part of the regulations and needs to be less complex, confusing and redundant. If not, claims professions will have a difficult time understanding it and will not use it.

I tried to be fair and objective in my review. There is much that will benefit us such as the 90 day limit on billing, not submitted on time no payment due, change of EOB to EOR, complete medical records for a UR and the requirements for UROs.

I took the liberty to forwarding a copy of my review to Ms. Wunsch, which will enable us to address the committee first. You are aware of the overall process and these recommendations may end up on the floor, however they may not. While regulations must necessarily follow the statue they need to be understandable by the professionals that use them, this was the background I used in my review.

Thank you,
John

ORIGINAL: 2542

Gelnett, Wanda B.

From: Wunsch, Eileen [ewunsch@state.pa.us]
Sent: Tuesday, July 11, 2006 4:17 PM
To: Henneman, Karla
Cc: Kupchinsky, John; Kuzma, Thomas J. (GC-LI); Howell, Thomas P. (GC-LI)
Subject: FW: SECOND REVIEW

KARLA,

This needs to be printed, distributed and logged in. It is additional comments from John Madigan.

Eileen K. Wunsch, MS, CPIW, ARM
Chief, Health Care Services Review
Bureau of Workers Compensation
Department of Labor & Industry
1171 South Cameron Street
Harrisburg, PA 17104
Phone: 717 772-1912
FAX: 717 772-1919
ewunsch@state.pa.us

-----Original Message-----
From: Hawkins, Krish [mailto:Krish.Hawkins@compservicesinc.com]
Sent: Tuesday, July 11, 2006 3:05 PM
To: 'Wunsch, Eileen'
Cc: Madigan, John
Subject: SECOND REVIEW

Please see attached.

Krish Hawkins
Provider Relations
CompServices, Inc.
1717 Arch Street, 45th Floor
Philadelphia, PA 19103
(215) 587-1997
(215) 561-1826 Fax
krish.hawkins@compservicesinc.com