ORIGINAL: 2542

Gelnett, Wanda B.

From: Wunsch, Eileen [ewunsch@state.pa.us]
Sent: Tuesday, July 11, 2006 7:44 AM
To: Henneman, Karla
Cc: Kupchinsky, John; Kuzma, Thomas J. (GC-LI); Howell, Thomas P. (GC-LI)
Subject: FW: Reg Comments

KARLA,

These need to be printed, distributed and logged in. Thanks.

Eileen K. Wunsch, MS, CPIW, ARM
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Bureau of Workers Compensation
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-----Original Message-----
From: Kathy DeWittie [mailto:pos@paorthosociety.org]
Sent: Monday, July 10, 2006 4:22 PM
To: ewunsch@state.pa.us
Subject: Reg Comments

Hi Eileen

Attached are the Orthopaedic Society's comments. Thanks for the opportunity and I'll see you tomorrow.

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July 10, 2006

Eileen Wunsch
Chief, Health Care Services Review Division
Bureau of Workers' Compensation
Dept. of Labor & Industry
1171 South Cameron Street
Harrisburg, PA 17104-2501

Dear Ms. Wunsch:

Thank you for the opportunity to comment on the proposed regulations of the Pennsylvania Workers' Compensation Act. We truly appreciate your extensive efforts to improve the delivery of efficient and quality medical care to Pennsylvania's injured workers through this process. We respectfully submit the following comments for your consideration.

Existing Regulation:	**Proposed Regulation:**
127.3 Definitions *Usual and customary charge*—The charge most often made by providers of similar training, experience and licensure for a specific treatment, accommodation, product or service in the geographic area where the treatment, accommodation, product or service is provided.	127.3 Definitions *Usual and customary charge*--The charge most often made by providers of similar training, experience and licensure for a specific treatment, accommodation, product or service in the geographic area where the treatment, accommodation, product or service is provided, **as evidenced by a database published or referenced by the Department in the *Pennsylvania Bulletin*.**

COMMENT:
There are a number of UCR databases available, some more reliable than others. We would like to know and to have the opportunity to comment on the specific database(s) the Department proposes to publish or reference, before implementing this proposed change.

Existing Regulation:

§ 127.201. Medical bills—standard forms

(a) Requests for payment of medical bills shall be made either on the HCFA Form 1500 or the UB92 Form (HCFA Form 1450), or any successor forms, required by HCFA for submission of Medicare claims. If HCFA accepts a form for submission of Medicare claims by a certain provider, that form shall be acceptable for billing under the act.

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

Proposed Regulation:

§ 127.201. Medical bills**[--standard forms] generally**

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

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

(d) A provider may not seek payment from the insurer or employee if the provider failed to request payment within the time set forth in subsection (c).

(e) A provider may not bill, accept payment for, or attempt to recover from the employee, employer or insurer, charges relating to services that are beyond the scope of the provider's practice or licensure, under the laws of the jurisdiction where the services are performed.

COMMENT:

We recommend that subsection (c) allow the provider 180 days to bill as well as provide for exceptions to the rule. A survey of our membership showed that there are many instances where the provider has no knowledge that the injury is work-related until well past the first 90 days. Some examples:

- Patients will sometimes treat under commercial insurance first, only to realize later that the problem is work related. Providers could lose their ability to file a claim with the workers' compensation carrier, if the process extends beyond 90 days.

- A patient begins treatment for an injury or disorder, declaring to the physician in writing that the problem is not work related. He or she subsequently changes his or her mind and files a work claim. The patient then completes a coordination of benefits form indicating the condition is work related, outside of the proposed 90 day window. The insurer demands a refund for prior services paid and the worker's compensation carrier rejects the bill as untimely.

- The patient gives no indication that the injury is work-related. The provider bills their private insurer. Meanwhile, the patient gets an attorney and the provider gets written notification that the case is workers' comp.

The proposed regulations could further require that providers must request payment within 180 days of the issuance of a trigger document which indicates the acceptance of an injury as work-related.

Notice of Compensation Payable

We recommend that the NCP form be revised to include an additional copy which could be enclosed with the first payment sent to the provider. We recognize the Bureau's concerns about information unrelated to treatment which appears on the form; however, this final page of the NCP could be designed to omit those blocks containing compensation benefits and other information unrelated to medical treatment.

As is the intent of revised § 127.201 above, adoption of this recommendation would assist in the consistent, timely billing of insurers by providers for workers' compensation patients because the ambiguity of whether or not an injury is work-related would be removed.

An alternative would be to establish a secure, web-based or other electronic means of providing the "Description of Injury" to the provider.

Existing Regulation:	**Proposed Regulation:**
§ 127.203. Medical bills—submission of medical reports	§ 127.203. Medical bills--submission of medical **[reports] documentation.** **(e) The insurer is not obligated to make payment until 30 days after its receipt of the bill, Medical Reports and the Medical Report Form.**

COMMENT:
With reference to § 127.203(e) we recommend this revision: **The insurer is obligated to make payment within 30 days of its receipt of the bill, Medical Reports and the Medical Report Form.** This language is consistent with § 127.208 (a): "Payments for treatment rendered under the act shall be made within 30 days of the insurer's receipt of the bill…"

Existing Regulation:	**Proposed Regulation:**
§ 127.256. Administrative decision on an application for fee review. When a provider has filed all the documentation required and is entitled to a decision on the merits of the application for fee review, the Bureau will render an administrative decision within 30 days of receipt of all required documentation from the provider. The Bureau will, prior to rendering the administrative decision, investigate the matter and contact the insurer to obtain its response to the application for fee review.	§ 127.256. Administrative decision **and order** on an application for fee review. (a) [When] The Bureau will render an administrative decision and order if a provider has filed [all] the application, proof of service and all documentation required by § 127.203 (relating to medical bills--submission of medical documentation) unless the application will be returned under § 127.255 (relating to premature applications for fee review) [and is entitled to a decision on the merits of the application for fee review, the Bureau will render an administrative decision within 30 days of receipt of all required documentation from the provider].

COMMENT:
The omission of the timely rendering of an administrative decision is inconsistent with standard operating

procedures of general administrative practices.

If the administrative decision process absorbs more than 30 days, then perhaps an extension of the time frame to 45 or 60 days is more appropriate than elimination of a timely response altogether.

127.209 Explanation of Reimbursement

COMMENT:
We strongly support and greatly appreciate the new EOR section. Clarification of the insurer's decision to pay, downcode or deny payment of medical bills will be very helpful to providers.

Existing Regulation:	**Proposed Regulation:**
§ 127.260. Fee review adjudications.	§ 127.260. Fee review adjudications.
(a) The hearing officer will issue a written decision and order within 90 days following the close of the record. The decision will include all relevant findings and conclusions, and state the rationale for the fee review adjudication.	**(a)** The hearing officer will issue **a fee review adjudication consisting of** a written decision and order **[within 90 days]** following the close of the record. The decision **and order** will include all relevant findings and conclusions, and state the rationale for the fee review adjudication.

COMMENT:
The omission of the timely rendering of the hearing officer's written decision is inconsistent with standard operating procedures of general administrative practice.

If this decision process absorbs more than 90 days, then perhaps and extension of the time frame to 120 days is more appropriate than elimination of a timely response altogether.

Existing Regulation:	**Proposed Regulation:**
§ 127.457. Time for requesting medical records.	§ 127.851. Requesting and providing medical records
A URO shall request records from the treating providers listed on the request for UR within 5 days from receipt of the Bureau's notice of assignment.	(a) A URO shall request records from the treating providers listed on the request for UR within 5 days of the date of the Notice of Assignment. (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 work injury. The URO shall submit the request to the provider by certified mail. (c) The provider under review shall mail all requested medical records to the URO within 15 days of the postmark date of the URO's request. (d) Upon a URO's request for medical records under § 127.841 and 127.842 (relating to requests for UR--recertification; and requests for UR--redetermination), the provider under review shall mail all requested medical records to the URO within 7 days of the postmark date of the URO's request.

COMMENT:
Regarding 127.851(c) and (d), we recommend that the provider be permitted to transmit medical records by mail or facsimile. With respect to requests for medical records relating to requests for UR-recertification and UR-determination, we recommend that the provider have 15 days to transmit the records by mail or facsimile consistent with (c).

Thank you for your consideration.

Sincerely,

Joshua Port

Joshua Port, MD
President