ORIGINAL: 2542

Gelnett, Wanda B.

From: LI, BWC-Administrative Division [RA-LI-BWC-Administra@state.pa.us]
Sent: Tuesday, July 11, 2006 7:40 AM
To: Wunsch, Eileen; Kupchinsky, John; Kuzma, Thomas J. (GC-LI); Howell, Thomas P. (GC-LI)
Subject: Comments on Regs. from Karla

-----Original Message-----
From: PARF Mail [mailto:parfmail@parf.org]
Sent: Monday, July 10, 2006 5:46 PM
To: ra-li-bwc-administra@state.pa.us
Subject: Chapter 127 Regulations --Comments

Attached are comments from the Pennsylvania Association of Rehabilitation Facilities on the Proposed Rulemaking of the Department of Labor and Industry Commonwealth of Pennsylvania on 34 PA. Code Chapter 127 - Medical Cost Containment as published in the *Pennsylvania Bulletin* on June 10, 2006.

PARF and its members appreciate the opportunity to comment and to recommend changes to the proposed regulations.

If more information or assistance is needed, please contact PARF at parfmail@parf.org.

PARF

Pennsylvania Association of Rehabilitation Facilities
2400 Park Drive, Harrisburg, PA 17110 Phone 657-7608 Fax: (717) 657-8265

July 7, 2006

Eileen Wunsch
Health Care Services Review Division
Bureau of Workers' Compensation
Commonwealth of Pennsylvania
Department of Labor and Industry
Chapter 127 Regulations – Comments
PO Box 15121
Harrisburg, PA 17105

Dear Ms. Wunsch:

Attached are comments from the Pennsylvania Association of Rehabilitation Facilities on the Proposed Rulemaking of the Department of Labor and Industry Commonwealth of Pennsylvania on 34 PA. Code Chapter 127 - Medical Cost Containment as published in the *Pennsylvania Bulletin* on June 10, 2006.

PARF and its members appreciate the opportunity to comment and to recommend changes to the proposed regulations.

If more information or assistance is needed, please contact PARF at parfmail@parf.org.

Sincerely,

Gene Bianco
President/CEO

Pennsylvania Association of Rehabilitation Facilities
Comments on Workers' Compensation on Proposed Regulations
June 7, 2006

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*.**

Proposed: The Department proposes an amendment to the language of the definition of "Usual and Customary Charge":

PARF Comment: The Bureau is seeking to more fully define the term usual and customary charge. The proposed amendment to the regulations does not provide language that clearly defines the charge and does not add precise qualifications to the term. The "database" is not referenced. The type of evidence is that would be published or referenced is not clear.

127.107 - MEDICARE FEE SCHEDULE

Text: § 127.107. Outpatient providers subject to the Medicare fee schedule--physical therapy centers and independent physical therapists.

(a) Payments to outpatient physical therapy centers and independent physical therapists not reimbursed in accordance with § 127.118 (relating to RCCs--generally) shall **initially** be calculated by multiplying the Medicare Part B reimbursement for the services by 113%.

(b) Payment for services rendered under this section on and after January 1, 1995, will be frozen as of December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.

(c) On and after January 1, 1995, adjustments and modifications by CMS relating to a change in description or renumbering of a CPT or HCPCS code will be incorporated into the basis for determining the amount of payment as frozen under subsection (b) for services rendered under the act.

(d) On and after January 1, 1995, payment rates under the act for new CPT or HCPCS codes will be based on the rates allowed in the Medicare fee schedule published in the *Federal Register* within the calendar years of the effective date of the new codes. These payment rates will be frozen immediately, and thereafter updated annually by the percentage change in the Statewide average weekly wage.

Proposed: The Department proposes amending § 127.107 (relating to outpatient providers subject to the Medicare fee schedule--physical therapy centers and independent physical therapists) to clarify the means of updating physical therapy centers' and physical therapists' reimbursement rates.

PARF Comment: New services should be defined according to the CPT or HCPCS codes. Certain services such as work hardening may not be eligible for payment under Medicare but may be used in Workers Compensation systems since the service may be appropriate to injured workers. Medicare system should be used as a basis for definition but not as a basis for allowing or disallowing a medical procedure that is defined by the American Medical Association in its Common Procedure Terminology (CPT) coding system.

127.117 – MEDICARE PAYMENT

Text: **§ 127.117.** Outpatient acute care providers, specialty hospitals and other cost-reimbursed providers [not subject to the Medicare fee schedule].

(a) The following services shall be paid on a cost-reimbursed basis for medical treatment rendered under **[Act 44] the act:**

* * * * *

(b) As of December 31, 1994, the provider's actual charge by procedure as determined from the charge master shall be multiplied by the ratio of cost-to-charges, based on the most recently audited Medicare cost report. Except as stated in subsection (c), this amount will be frozen as of December 31, 1994 for purposes of calculating payments under the act and updated annually by the percentage change in the Statewide average weekly wage.

(c) To calculate rates frozen in subsection (b), the Bureau will multiply the provider's billed charges by the RCC associated with the appropriate Revenue Code. The appropriate Revenue Code is the Revenue Code that applies to the corresponding service descriptor in the charge master as of September 1, 1994, or the Revenue Code that applies to the corresponding service descriptor added to the charge master under subsection (f)(2).

(d) Subsection (b) will not apply when the charge master does not contain unique charges for each item of pharmacy and when actual charges are based on algorithms or other mathematical calculations to compute the charge. For purposes of effectuating the freeze, the providers' RCC for pharmacy (drug charges to patients) will be frozen based on the last audited Medicare cost report as of December 31, 1994. On and after January 1, 1995, the providers' actual charges shall be multiplied by the frozen RCC and then by 113% to determine reimbursement. These payments may not be updated based on changes in the Statewide average weekly wage.

(e) Providers that are reimbursed under this section and add new services requiring the addition of new service descriptors within previously reported Medicare revenue codes and frozen RCCs shall receive payment based on the charge associated with the new service multiplied by the frozen RCC.

(f) Providers that are reimbursed under this section and add new services requiring the addition of new service descriptors outside of the previously reported Medicare revenue codes and frozen RCCs, shall receive payment as follows:

(1) Before the completion of the audited cost report that includes the new services, payment shall be based on 80% of the provider's usual and customary charge.

(2) Upon completion of the first audited cost report that includes the new services, payment shall be based on the charge associated with the new service multiplied by the audited RCC including the charge. Payment rates shall be frozen immediately and updated annually by the percentage change in the Statewide average weekly wage.

(g) Providers reimbursed under this section that, commencing _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposed rulemaking.), add new services for which the providers are reimbursed by Medicare on a fee-for-service basis,

shall receive reimbursement according to the procedures established under this chapter for Medicare Part B services.

(h) Providers that are reimbursed under this section and add new services under subsections (f) or (g) shall provide the service descriptor, HCPCS codes, applicable Medicare revenue codes and applicable cost data to the Bureau within 30 days of the date on which the provider first provides the new service. The Bureau will include all reimbursement rates relating to the new service in the next publication of the charge master. Providers shall thereafter be reimbursed for the service as set forth in the charge master, and may not assert that the service is new as set forth in subsection (f)(1).

Proposed: The Department proposes amending § 127.117 (relating to outpatient acute care providers, specialty hospitals and other cost-reimbursed providers not subject to the Medicare fee schedule) to clarify the means for updating reimbursement rates under this section. In addition, the Department proposes amending the means of identifying services in the charge master by reference to service descriptors instead of service codes. Further, the Department proposes amending this section to provide the means for incorporating new codes and new services under this section. Finally, the Department proposes amending this section to provide that providers that, after the effective date of the proposed rulemaking, add new services for which Medicare reimburses on a fee-for-service basis will be reimbursed under this section on a fee-for-service basis.

PARF Comment: The Department is seeking to conform the regulations to the current Medicare payment systems. The objective of original legislation was to use the Medicare payment system as a basis for payment but not as a determinant for the coverage of a particular service. Caution should be taken to maintain the separation between the Medicare payment system and the rules that determine coverage of a service. Thus, CPT codes and HCPCS codes may be used as descriptors of a service but the changing Medicare rules on coverage should not be imported into the workers compensation system. The cost to charge ratio as mandated under the law should be used.

TIME LIMIT

Text: § 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.

Proposed: The Department proposes rescinding § 127.201 (relating to medical bills--standard forms) to require that providers request payment for medical bills and provide all required information to insurers within 90 days of the employee's first date of treatment with that provider. The Department further proposes amending this section to provide that failure to request payment as set forth in this section shall result in a waiver of any right to proceed against the insurer or claimant for payment of the bills. Additionally, the Department proposes adding a provision to clarify that providers may not bill or accept payment for services that are beyond the scope of their practice or licensure.

PARF Comment: The limit on time frame is overly restrictive in light of the possibility that documentation on services, paperwork, medical reports (LIBC-9) and other billing documentation that is required will in certain cases be provided in a period longer than ninety days. No other major payment system has such a short time frame.

BUNDLING/UNBUNDLING

Text: § 127.204. Fragmenting or unbundling of charges by providers.

A provider may not fragment or unbundle charges except as consistent with **the Correct Coding Initiative in effect on the date of service**.

Proposed: The Department proposes amending § 127.204 (relating to fragmenting or unbundling of charges by providers) to provide that fragmenting and unbundling of charges is only permitted where it is consistent with the most recent Medicare Correct Coding Initiative in effect on the date of service of the treatment, service or accommodation.

PARF Comment: Medicare Part-A providers and other specialty providers may currently have a payment rate that is based on established service codes as defined in the individual fee schedule and in conformity with the requirements of the Act. This proposed change should indicate that regulation is not applicable to such providers.

REFERRAL

Text: § 127.302. Resolution of referral disputes by Bureau.

(a) If an insurer determines that a **[bill has been submitted for] billed** treatment **has been** rendered in violation of the referral standards, the insurer is not **[liable] required** to pay the bill. **[Within 30 days of receipt of the provider's bill and medical report, the] An** insurer shall supply a written **[explanation of benefits] EOR** under § 127.209 (relating to explanation of reimbursement paid), stating the basis for believing that the **[self-referral provision has] referral standards have** been violated.

Proposed: The Department proposes amending § 127.302 (relating to resolution of referral disputes by Bureau) to provide that insurers asserting that the referral standards have been violated must do so through an EOB.

PARF Comment: The Department should add clarifying language on violations of referral standards. The Department should allow for proper enforcement of the standards that prohibit referral by a physician of patients to another physician or health care provider with whom the referring physician has an ownership interest. A mechanism should be described in this section of the regulations that would allow for proper enforcement.