Comments to Proposed Rulemaking

Charles S. Katz, Jr. - SWARTZ CAMPBELL LLC

Section 127.129 - Out-of-State Medical Treatment.

The effect of the Department's proposed amendment to Section 127.129 is to eliminate fee caps for out-of-state providers. This proposed amendment should be deleted.

The Act itself provides for fee caps at §306(f.1)(3)(i). It contains no exception to the fee caps for out-of-state medical providers. This proposed amendment is contrary to the Act and would be invalid if adopted. Its adoption would, however, leave a regulatory void wherein the level of reimbursement of out-of-state providers could not be calculated.

The Department's stated concern that "this requirement has proven to be unenforceable and has provided false assurance to individuals seeking treatment from out-of-state providers who seek to 'balance bill' injured employees" can be addressed in other ways. It is simple enough to caution injured workers about out-of-state providers by adding a sentence or two to the employer's posted list of panel physicians. It would also help if the Department were more proactive in telling out-of-state providers that they are subject to the Pennsylvania fee caps and that they violate Pennsylvania law when they balance bill injured workers.

In short, the Department should not attempt to legislate by regulation and this proposed amendment certainly appears to be an attempt to do so. The intention of Act 44 of 1993 was to decrease medical costs for Pennsylvania insurers. This proposal is a step in the opposition direction.

Comments to Proposed Rulemaking

Charles S. Katz, Jr. - SWARTZ CAMPBELL LLC

Section 127.201 - Medical Bills Generally.

The Department proposes to add sub-section (c) which would require providers to "provide all applicable reports required under Section 127.203 within 90 days from the first date of treatment reflected on the bill. This proposal would have the effect of increasing the time for submission to the insurer of the only required report, form LIBC-9. The amendment would be invalid if adopted.

Section 306(f.1)(2) requires providers to submit medical reports within 10 days of commencing treatment and at least once a month thereafter except for months in which no treatment is rendered. This requirement is phrased in mandatory terms. There is nothing equivocal in the phraseology of the Act which suggests the need for regulatory clarification.

As the law stands now, a provider who does not submit a medical report form within 10 days of commencing treatment and at least once a month thereafter, as long as treatment continues, is barred from collecting for the treatment provided.

What Section 306(f.1)(2) of the Act does not tell us is when the provider's bills need to be submitted. Thus, it seems to us that the Department can validly require that bills be submitted within 90 days from the first date of treatment reflected on the bill without the regulation contradicting the Act. This distinction should be made clear in a revised amendment to Section 127.203.

ORIGINAL: 2542

Comments to Proposed Rulemaking

Charles S. Katz, Jr. - SWARTZ CAMPBELL LLC

Section 127.209 - Explanation of Benefits Reimbursement Paid.

The proposed amendment to sub-section (a) requires clarification of the term "in a Department - prescribed format ..." There are at least 16 purely "legal" reasons that payment of a medical bill should be denied. There are probably 150 technical "re-pricing" reasons for denying payment of a medical bill in whole or in part. We have difficulty with the concept of the Department prescribing a form of EOR that covers the whole landscape.

If, on the other hand, a "format" will simply enumerate a few basic requirements of the form to be used by the insurer, it seems to us that the regulation should spell out those requirements so everyone will know what the Department has in mind.

The proposed amendments and additions to Section 127.209(b) reinforce our concerns. Six reasons for denial are listed. If this is thought to be a complete list of even the basic "legal" reasons for denial of a bill, it falls at least ten reasons short. The regulation should either be all inclusive of reasons for denial or should be silent on the matter. Silence would seem preferable here, and we would therefore recommend clarification of sub-section (a) and deletion of sub-section (b).

ORIGINAL: 2542

Comments to Proposed Rulemaking

Charles S. Katz, Jr. - SWARTZ CAMPBELL LLC

Section 127.211 - Balance Billing Prohibited.

While we applaud the amendments to sub-sections (a), (b) and (c) of this regulation, we strongly urge deletion of sub-section (d) which has the effect of creating an automatic penalty upon an insurer that exercises its right under the Act to deny a questionable claim if, after litigation, denial of compensability or other reason for denial of the bill is found to be "improper" or "incorrect."

First, the term "improper" requires clarification. It should be rigidly defined in the regulation or deleted.

Second, the use of the term "incorrect" means that an insurer who loses in litigation, if the facts are decided adversely to it or if its legal position is not upheld, will automatically be penalized. The legislature did not intend to penalize insurers for asserting valid defenses. If adopted, this proposed addition to Section 127.211 would unfairly dampen insurers' willingness to assert defenses and to contest questionable claims since it would penalize them automatically if they lost on the factual or legal issues. That is undesirable.

Failure to issue an EOR in a timely fashion would be a violation of the new proposed regulations. To specifically prescribe a penalty for ill-defined conduct that does not violate the Act is wrong.

ORIGINAL: 2542

Comments to Proposed Rulemaking

Charles S. Katz, Jr. - SWARTZ CAMPBELL LLC

Section 127.259(d) - Fee Review Hearing.

The proposed amendment to this sub-section would have the effect of eliminating access to fee review to all but the smallest providers, who are sole proprietors or partnerships, and the largest providers, who have staff counsel. The vast majority of providers between the two extremes, particularly those trading in a corporate format, would have to have a corporate officer appear in the fee review hearing or hire an attorney. In most instances, the money involved in a fee review hearing is insufficient to justify the participation of the physician/corporate officer or the retention of counsel.

On the insurer's side, a corporate officer would have to appear in the fee review proceeding except in the case of a government agency or a political sub-division on whose behalf any employee could appear. Accordingly, most insurers would also be deprived of practical access to fee review because the monies involved do not justify personal attendance of a corporate officer or to merit the retention of counsel.

It seems to us that the Department should encourage providers and insurers to participate in the fee review process. The amendment should eliminate the need for participation by corporate officers and should make legal representation unnecessay , not require it.

We recommend revision of proposed sub-section (d) in order to prevent the death of fee review.

ORIGINAL: 2542

Comments to Proposed Rulemaking

Charles S. Katz, Jr. - SWARTZ CAMPBELL LLC

Section 127.752 - Contents of List of Designated Providers.

The proposed amendment to sub-section (b) would prohibit the employer from requiring the employee to report to a single point of contact before receiving treatment from a provider on the list. This prohibition is undesirable. Just because something is helpful to the employer, does not mean that it is necessarily injurious to the employee.

It should be observed initially that the requirement to report to a single point of contact is not unlike the present reporting requirements of the Act under Sections 311 and 312. Also, there is nothing that prevents an employee from obtaining emergency care before reporting to the single point of contact.

The Act and present regulations require the employer to explain rights and duties to the injured worker and to obtain re-execution of the notification of rights and duties form. These two things go hand in hand. Employers with risk managers on the premises who are conversant with workers' compensation and employers with occupational health nurses on the premises who are capable of actually explaining an employee's rights and duties are the exception, not the rule. It is not surprising that employers have sought the advice of knowledgeable people and have retained them to perform this function on their behalf. The important thing is that the rights and duties of an injured worker be explained to him accurately. This benefits the employee.

The addition of sub-section (e) proposes that any reference to a single point of contact or referral makes all providers "associated" with the point of contact or referral a "single provider." First, the term "associated" is quite broad and needs to be well defined.

Second, it seems to us that a single point of contact for scheduling of appointments should be encouraged, not discouraged. Once again, there are benefits to both the employer and employee. The employer can manage its workers' compensation injuries more effectively during the first 90 days permitted by the Act than it would be able to do if the employee is left to guess at the proper specialist to treat his injury. The employee benefits from assistance in scheduling medical care with the appropriate specialist in an expeditious manner. An expert who can access

providers more easily than can the worker makes the appointments. The net result is an increase in employee access to medical services of the best available physicians.

Section 127.752(e) should be deleted in its entirety and replaced by a section that requires employers to provide single point of contact scheduling services.

Comments to Proposed Rulemaking

Charles S. Katz, Jr. - SWARTZ CAMPBELL LLC

Section 127.822 - Pre-certification - Insurer Obligations.

Sub-section (d) as proposed requires clarification. As presently worded, it states "if a workers' compensation Judge determines that the insurer 'improperly' denied the existence of a causal relationship or liability for the injury, penalties may be assessed under Section 435 of the Act. The Department should be reminded that the legislature has prescribed that a penalty may be assessed where there has been a violation of the Act or regulations. The proposed regulation appears to be an attempt to expand the circumstances under which a penalty assessment would be permitted and, as such, is inconsistent with the limitations of Section 435(d) of the Act.

In addition, deciding what is "improper" is at best a guessing game and a matter of individual interpretation. The standard is insufficient to define the conduct which is prohibited.

Sub-section (f) suffers from the same problems. If an insurer presents a medical opinion that certain treatment is not reasonable and necessary, but the WCJ chooses to believe another medical expert and to decide that the treatment is reasonable and necessary, his decision should not be the basis for imposition of a penalty since there has been no violation of the Act. Sub-section (f) should be deleted in its entirety.

ORIGINAL: 2542

Comments to Proposed Rulemaking

Charles S. Katz, Jr. - SWARTZ CAMPBELL LLC

Section 127.833 - Continuing Effect of UR Determinations.

The Department should be applauded for the proposal of adding sub-section (c) that finally clarifies the obvious: a utilization review is treatment specific, not provider specific.

ORIGINAL: 2542

Gelnett, Wanda B.

From: LI, BWC-Administrative Division [RA-LI-BWC-Administra@state.pa.us]
Sent: Wednesday, July 12, 2006 7:48 AM
To: Wunsch, Eileen; Kupchinsky, John; Kuzma, Thomas J. (GC-LI); Howell, Thomas P. (GC-LI)
Subject: Reg. Comments from Karla

-----Original Message-----
From: Dawn M. Hensman [mailto:dhensman@swartzcampbell.com]
Sent: Tuesday, July 11, 2006 2:24 PM
To: rffaux@state.pa.us; bpratt@legioninsurance.com; georgehuckaby@aol.com; laguy@sunocoinc.com; dalet@cghinsurance.com; rrpiha@sunocoinc.com; Ra-LI-BWC-Administra@state.pa.us
Subject:

Sorry for the confusion but it seems as though Chuck made changes to these comments in my absence and it was never saved in Word. Please disregard the last word document I sent you and replace it with this new one.

ORIGINAL: 2542

Comments to Proposed Rulemaking

Charles S. Katz, Jr. - SWARTZ CAMPBELL LLC

Section 127.906 - Petition for Review by Bureau - Hearing and Evidence.

Sub-section (d) appears to be inconsistent with sub-section 127.861 (c) that makes it clear that a provider who fails to participate in the first stage of the utilization review process may not introduce evidence before the WCJ. The word "shall" should be substituted for the word "may" in this proposed regulation. The disregard of offered evidence should be mandatory or the provider under review should be prohibited from introducing any evidence at all in accord with present case law.