Original: 2542

Lancaster General

July 12, 2006

Eileen Wunsch
Chief, Health Care Services Review Division
Bureau of Workers' Compensation
Department of Labor and Industry
Chapter 127 Regulations – Comments
P.O. Box 15121
Harrisburg PA 17105

Dear Ms.Wunsch:

I am writing on behalf of Lancaster General Hospital (LGH) with regard to the proposed rulemaking for the Department of Labor and Industry's June 10, 2006 publication related to changes to Chapter 127 – relative to workers' compensation medical cost containment.

We would like our comments considered when finalizing any changes to the regulations.

Section 127.109
To require that providers specifically identify supplies, as proposed under this section is impossible for our hospital to provide the detail you request. The UB92 bill form is not designed to provide a significant amount of data. We would request that you exclude hospitals (outpatient departments) due to the lack of the UB file format to provide the specifics you've proposed. (A detailed bill contains this information, but is not generated for reimbursement)

Section 127.117 {see also 127.210(b)}
Proposing that services would be identified by 'descriptors' instead of 'service codes' is unrealistic. Our facility uses the charge master to bill a variety of insurance carriers and our 'descriptors' contain terminology that would be pertinent to LGH, but not consistent with the industry 'descriptor'. This proposed change would cause a significant amount of change to our CDM and re-training of staff involved, as well as place a heavier burden on the insurance industry. The service codes are consistent across insurers. Also, 'descriptors' would be an inefficient method for looking up payment rates, etc. Current rates are specifically identified by the service code billed. However, the most logical change to the charge master would be utilization of the industry standard CPT codes.

Section 127.117(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.

Denise A. Kennedy · Assistant Vice President, Finance
Lancaster General Hospital • 555 N. Duke Street • P.O. Box 3555 • Lancaster, PA, 17604-3555
(717) 544-5010 • Fax (717) 544-4724 • dakenned@LancasterGeneral.org • www.LancasterGeneral.org

As providers, we do not map RCCs based on revenue code only. The mapping of RCCs is often a function of the *mapping* schedule used in our reimbursement system. RCCs are created at a cost-center level and services or items contained within an individual cost center have different revenue codes. For example, radiology departments often contain items with the following revenue codes: 32x, 27x, 62x, 94x, 25x and 63x. Mapping these items that reside in the radiology department to any other RCC (based only on revenue code) would be inappropriate and inaccurate

Section 127.201(b)
Cost-based providers shall submit a detailed bill including the service 'descriptors' consistent with the service 'descriptors' 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 'descriptors' added under § [127.155(d) and (e)] 127.117(d)--(i).

Please see our comments under 127.117 above.

Section 127.201(c)
Due to many factors, establishing a 90 day time limit on payment for bills and reports from the first date of treatment reflected on the bill, is inadequate and unreasonable. Most timeframes for bill resolution is 1 year or longer, depending upon the entity. We would request that this section be deleted.

Section 127.851
To expect that the provider under review could pull, copy and mail all requested records to the URO within 15 days of the postmarked request is again, inadequate and unreasonable. Medical information is often decentralized in a hospital or other organization and can often take time to coordinate the compilation and submission. We would request that this time be increased to at least 30 days, if not 45 days.

We are supportive of necessary changes to various regulations to increase efficiency, contain costs and otherwise benefit patients, providers and insurance carriers, but it would appear that some of these proposed changes will actually decrease efficiency and place an administrative burden on hospitals, physicians, insurance carriers – and even the patient.

Thank you for allowing us to present our comments and recommendations.

Sincerely,

Denise A. Kennedy
Assistant Vice President, Finance

DAK/sjm

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