ORIGINAL: 2542

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To the Independent Regulatory Review Committee:

I kindly request that you consider these general comments and concerns regarding the Department of Labor and Industry proposed rulemaking to Chapter 127 (relating to Workers' Compensation Medical Cost Containment) of the Pennsylvania Workers' Compensation Act 44/57 as published in the June 10, 2006 issue of the Pennsylvania Bulletin.

It is of great concern in the proposed rulemaking by the Department to see the dramatic cut in the allowance of time for the review process overall. In the proposed rulemaking the provider is given 15 days from the date of the URO's written certified request to submit the medical records of the employee to the URO as compared to the 30 days the provider is now given under the current regulations for utilization review to submit the records to the URO. Also in the proposed rulemaking the provider is given 7 days for a recertification/redermination to forward the records. If the provider under review fails to mail the records to the URO within 15 days of the date of the URO's written request for the records, the URO is to render a determination that the treatment under review is unreasonable and unnecessary.

My concerns are these:
There are times when UR requests unknowingly list a wrong address for the provider under review and are initially processed as so by the URO when the written certified request is prepared and mailed. The new time lines that would be imposed under the rulemaking appear to be in my opinion, unfair to the provider, by only allowing the provider 15 days from the date of the URO's written certified request to submit the medical records to the URO, and 7 days to forward records for a recertification/redetermination.

Circumstances do happen. For example; what if the provider under review does not receive the written certified request because an incorrectly address was listed on the UR request or what if error is made by the United States Postal Service in delivering the certified mail piece to the provider? As the current regulations stand now, I truly believe that the 30 days given to the provider for submitting the medical records of the employee from the date of the URO's certified written request plays a "crucial" part in providing a fair process by ensuring a fair allowance of time for any such errors, if they would occur. The URO has no way of tracking the certified mail piece once mailed (other than waiting a number of days after the certified piece has been mailed) to allow the time for the mail piece to be accepted (scanned in) by the

other receiving postal office. Also, many times the URO doesn't obtain the knowledge that the UR request had listed the provider's address incorrectly until either the certified request is returned to the URO or the provider is contacted by telephone by the URO, whichever is earlier. Therefore, in the understanding that the UR process is not performed merely by matter of precise machine but by processes which include that of human transmission/processing i.e., placing a request in the hands of a postal worker, i.e., processing a request for records having

an incorrectly listed address on the UR request, I fear this would place the provider at a disadvantage as well as the employee, whose treatment under review would be found unreasonable and unnecessary because the records submission time deadline was not met. Circumstances do happen.

Also in regards to timelines, the proposed rulemaking of 127.862 states that the URO shall complete its review and render a determination within 20 days of a completed request for UR appears to be in "conflict with" the (Act) that is clear in stating "a utilization review organization shall issue a written report of its findings and conclusions within thirty (30) days of a request."

While it is apparent that the proposed rulemaking would impose a dramatic decrease in the review process (time-wise), by doing so it is worried that it may result in seeing a decrease of participating qualified reviewers (whom are not easily obtained) as reviewers may be unable to meet the burden of the shorter time-lines in completing a review and in also knowing the requirement of them in making the attempted contacts to the provider under review to discuss the case, if the provider has requested consultation. It is also worried that the reviewers may in fact increase their fees due to the more stringent timelines that would be imposed. For the individual files received by the URO that at many times are voluminous in size requiring more time to review, it is also worried that the proposed new timelines may be detrimental in the end, to the quality of the reviews in the rush of the reviewers having to meet the deadlines.

In the proposed rulemaking of 127.811 (relating to UR of entire course of treatment); the Department proposes to add: "any inconsistencies between reviewers will be resolved through consultation of the involved reviewers". I believe this will create bias as it could be viewed as the influencing of a reviewer's opinion by another.

The proposed rulemaking of 127.856 (relating to insurer submission of studies) states that "the insurer may submit peer-reviewed, independently funded studies and articles and reliable medical literature which are relevant to the reasonableness and necessity of the treatment under review to the URO." However, what about the provider and the employee? In an equality of fairness to all parties of the review I believe that the provider and the employee should then also be afforded the right to submit relevant literature as same, as relevant to the reasonableness and necessity of the treatment under review. With the multitude of current existing literature and ever-changing literature of the arts and sciences, who is to determine "what is" or "is not" considered reliable literature and what are the standards to ensure the submission of studies by the insurer can be relied upon? What if the material is questionable and the reviewer professionally and ethically believes the literature submitted is not reliable literature reflecting the current standards of care? In the proposed rulemaking of 127.855 regarding the Employee Personal Statement, it does not permit any type of enclosures, attachments or documentation to the statement and appears that the advantage is to the insurer by allowing the insurer the right to the submission of studies. In summary, I believe in all fairness to all parties that if this proposed rulemaking is to occur then the insurer, the provider, and the employee should all have the same equal rights regarding the "submission of studies."

The existing regulations of 127.453(a) provide that "the bureau will randomly assign a properly filed request for UR to an authorized URO. In the Proposed rulemaking of 127.806(a) "the bureau will assign a properly filed request for UR to an authorized URO." It is

taken notice that the word "randomly" is no longer present and I have always believed that the random assignment of UR is a process by which contributes a strong means of providing impartiality to the review process.

The proposed rulemaking of 127.861 requires the URO to issue a determination that treatment under review is unreasonable and unnecessary if the provider under review does not submit records within 15 days of the date of the UROs written request for records. I see no provision in the proposed rulemaking stating that the URO is to proceed with a review if the employee submits an employee personal statement to the URO in a timely manner. Currently, the Bureau requires the UROs to proceed with a review if no medical records are received by the treating provider under review but an employee personal statement has still been timely received.

The proposed rulemaking of 127.865 permits the same reviewer to make a determination on whether or not the continued treatment of an injured worker is reasonable and necessary. I believe this takes away from the impartiality of the review system and would create bias.

The proposed rulemaking of 127.1051 (relating to authorization of UROs/PROs) provides that the Bureau may authorize UROs/PROs through contracts awarded under 62 Pa.C.S. *relating to Commonwealth Procurement Code* and proposes that the Bureau will not be required to award a contract to every offeror that submits a proposal that meets the minimum requirements established by the request for proposal (RFP). Firstly, the "Act" is quite clear in stating that "The department shall authorize utilization review organizations to perform utilization review under this act".

Further, I fear this may result in seeing a significant decrease in the number of UROs existing in the Commonwealth by way of selective elimination of the qualified UROs who do meet the minimum requirements established by the request for proposal (RFP). This selective process by which the Bureau will not be required to award a contract to every offeror that submits a proposal that meets the minimum requirements established by the request for proposal (RFP) will keep a controlled number of qualified UROs remaining in operation while at the same time restricting other UROs who are just as qualified and who also meet the minimum requirements established by the request for proposal (RFP) from being authorized and/or awarded a contract. I can only feel that this, along with the removal of the randomization process by which UR requests are assigned, closes the door for the ability to maintain an impartial review system. It does appear that the proposed rulemaking is suggesting that the Department/Bureau is trying to control the UR process itself given the authority of selectively awarding contracts to UROs. Also, if the Procurement Code is utilized in the way the procurement code was intended for, it would mean that the Department/Bureau is intending to pay for the service of utilization review. Is it the intent of the Department/Bureau to pay for utilization reviews on behalf of the Insurer/employer? The authorization of UROs should come about through an impartial process based on the UROs qualified ability to comply with and demonstrate that it meets the requirements of the "Act", not by the use of any other means in which appears to be an attempt in control the UR process and UROs to the point that there may only be a few select UROs left in the Commonwealth.

Overall, it is my opinion that the proposed rulemaking is weighted more heavily to the advantage of the Insurer/Employer, and in turn creates a disadvantage for both the Employees and the Providers. I also feel that the importance of providing impartiality to all, has somehow been forgotten along the way. The review process was, after all, implemented to provide a means by which all parties, the insurers, employers, employees, and the providers would be afforded an unbiased process.

Sincerely,

WatsonReviewServices
Kathleen Watson

ORIGINAL: 2542

Kathy Cooper

From: Watsonuro@aol.com
Sent: Monday, July 10, 2006 9:07 PM
To: IRRC
Subject: General comments on proposed rulemaking

To the IRRC:

I kindly request that the attached comments be taken into consideration in regards to the proposed rulemaking for the Medical Cost Containment Act 44/57 sections of the Pennsylvania Workers' Compensation Act.

Watson Review Services
Authorized Utilization and Peer Review Organization

Kathleen Watson, Medical Case Coordinator and Owner