PHONE: (717) 783-5417
FAX: (717) 783-2664
irrc@irrc.state.pa.us
http://www.irrc.state.pa.us

INDEPENDENT REGULATORY REVIEW COMMISSION
333 MARKET STREET, 14TH FLOOR, HARRISBURG, PA 17101

August 9, 2006

Honorable Stephen M. Schmerin, Secretary
Department of Labor and Industry
1700 Labor and Industry Building
Harrisburg, PA 17120

Re: Regulation #12-72 (IRRC #2542)
Department of Labor and Industry
Medical Cost Containment

Dear Secretary Schmerin:

Enclosed are the Commission's comments for consideration when you prepare the final version of this regulation. These comments are not a formal approval or disapproval of the regulation. However, they specify the regulatory review criteria that have not been met.

As noted in our comments, we received a copy of the notice the Department submitted to the *Pennsylvania Bulletin* indicating that the proposal as originally published did not accurately reflect the Department's intent to rescind Subchapter C and replace it with Subchapter E. As we understand, a corrected version of the Annex is to be published along with the notice. The Department is reopening the public comment period to allow comment relating only to this correction.

As the notice and corrected Annex will be published after the deadline for Commission comments, the Commission reserves the right to amend or supplement these comments relating to the deletion of Subchapter C and the replacement provisions in Subchapter E within 30 days of the close of the reopened public comment period, pursuant to Section 5(g) of the Regulatory Review Act (71 P.S. § 745.5(g)).

When the final-form regulation is delivered, we ask the Department to respond to our original comments issued today and any additional comments that IRRC may issue. If the final-form regulation is not delivered within two years of the extended public comment period, the regulation will be deemed withdrawn.

We also respectfully request the Department to comply with Section 5(c) of the Regulatory Review Act (71 P.S. § 745.5(c)), which requires an agency to submit a copy of comments it receives within five business days of receipt.

The comments will be available on our website at www.irrc.state.pa.us. If you would like to discuss them, please contact me.

Sincerely,

Kim Kaufman
Executive Director
wbg
Enclosure
cc: Honorable Joseph B. Scarnati, III, Chairman, Senate Labor and Industry Committee
Honorable Christine M. Tartaglione, Minority Chairman, Senate Labor and Industry Committee
Honorable Bob Allen, Majority Chairman, House Labor Relations Committee
Honorable Robert E. Belfanti, Jr., Democratic Chairman, House Labor Relations Committee

Comments of the Independent Regulatory Review Commission

on

Department of Labor and Industry Regulation #12-72 (IRRC #2542)

Medical Cost Containment

August 9, 2006

We submit for your consideration the following comments on the proposed rulemaking published in the June 10, 2006 *Pennsylvania Bulletin*. Our comments are based on criteria in Section 5.2 of the Regulatory Review Act (71 P.S. § 745.5b). Section 5.1(a) of the Regulatory Review Act (71 P.S. § 745.5a(a)) directs the Department of Labor and Industry (Department) to respond to all comments received from us or any other source.

GENERAL

1. Subchapter C. Medical Treatment Review. – Compliance with the Regulatory Review Act or the regulations of the commission in promulgating the regulation.

We received a copy of the notice the Department submitted to the *Pennsylvania Bulletin* indicating that the proposal as originally published did not accurately reflect the Department's intent to rescind Subchapter C and replace it with Subchapter E. As we understand, a corrected version of the Annex is to be published along with the notice. The Department is reopening the public comment period to allow comment relating only to this correction.

As the notice and corrected Annex will be published after the deadline for Commission comments, the Commission reserves the right to amend or supplement these comments relating to the deletion of Subchapter C and the replacement provisions in Subchapter E within 30 days of the close of the reopened public comment period, pursuant to Section 5(g) of the Regulatory Review Act (71 P.S. § 745.5(g)).

2. Determining whether the regulation is in the public interest.

Section 5.2 of the Regulatory Review Act (71 P.S. § 745.5b) directs this Commission to determine whether a regulation is in the public interest. More specifically, under §745.5b(b)(3)(iii), the Commission must determine the need for the regulation. To make that determination, the Commission must analyze the text of the proposed rulemaking and the reasons for the new or amended language. In the Preamble to this regulation, the Department has described the purpose of this rulemaking as follows:

> By this proposed rulemaking, the Department seeks to address and correct uncertainties, competing interpretations and administrative obstacles encountered during the administration of Chapter 127. Further, the Department intends to

remedy inefficiencies in the Medical Cost Containment system and to update terminology and processes used and described in the regulations to better reflect current practices, procedures and definitions.

While this is a good summary of the goals of the rulemaking, the Department has failed to provide detailed explanations of the specific need for each of its changes and how those changes will accomplish the Department's goal of a more up-to-date and efficient regulation. Without this information, we cannot evaluate the need for the proposed amendments to the regulation. In the Preamble to the final-form rulemaking, the Department should provide more detailed explanations of the reasons behind each of its amendments.

3. Timeframes. – Consistency with statute; Implementation procedures; Clarity.

Section 435(a) of the Pennsylvania Workers' Compensation Act (77 P.S. § 991(a)) (Act) states:

> The department shall establish and promulgate rules and regulations consistent with this act, which are reasonably calculated to:
>
> (i) expedite the reporting and processing of injury cases,
>
> (ii) insure full payment of compensation when due,
>
> (iii) expedite the hearing and determination of claims for compensation and petitions filed with the department under this act,
>
> (iv) provide the disabled employe or his dependents with timely notice and information of his or their rights under this act
>
> (v) explain and enforce the provisions of this act.

The Department is deleting timeframes from Sections 127.210(a), 127.256(a) and 127.260(a). In addition, many of the sections under Subchapter E lack timeframes within which the parties are required to act. For example, §127.809(b) is a vague requirement for the Bureau to "promptly" notify the utilization review organization (URO) of a withdrawal and § 127.1005(a) is also vague by stating, "The Bureau will assign a properly filed request for peer review to an authorized PRO [peer review organization]." To be consistent with Section 435(a) of the Act, specific timeframes should be maintained or added to all sections that require certain parties to take action. If the Department believes a specific timeframe is not appropriate in a particular instance, it should explain how that provision then meets Section 435(a) of the Act.

4. Forms. –Implementation procedures; Clarity.

This proposed regulation references various forms. Section 2.10(b) of the Pennsylvania Code & Bulletin *Style Manual* states the following: "If the agency feels that a legal basis is needed for requesting the submission of the information on the form, the regulations should list the information to be required, followed by language such as: This information shall be submitted on a form provided by the Department." If the Department believes there is a legal basis for requesting the information contained in these forms, that information should be included in the regulation.

Subchapter A. PRELIMINARY PROVISIONS

5. Section 127.2. Filing and service--computation of time. – Need; Clarity.

Computation of days

The Department is deleting the phrase "Unless otherwise provided, references to 'days' in this chapter mean calendar days." Without this phrase, the regulation is confusing because the body of the regulation does not specify whether days are calendar or business days. Therefore, we recommend retaining this phrase in regulation.

Subsection (a) Filing deemed complete

This subsection states, "A filing required by this chapter is deemed complete upon delivery in person or, if by mail, upon deposit in the United States Mail, as evidenced by a United States Postal Service postmark, properly addressed, with postage or charges prepaid." Since other provisions in Chapter 127 specify the content of filings, we recommend amending Subsection (a) to just apply to the service of documents.

6. Section 127.3. Definitions. – Clarity; Economic impact; Need.

ASC – Ambulatory Surgery Center

A distinction was made by a commentator that Class A ASCs are not licensed by the Department of Health, but must register with them. The Department should review this definition to make sure it does not unintentionally exclude valid ASCs.

Audited Medicare cost report

Commentators questioned the meaning of the phrase "or a successive mechanism used by Medicare to determine program or reimbursement rates." One commentator believes this phrase is inconsistent with the rest of the regulation since other parts of the regulation do not change to the successive mechanism used by Medicare. The Department should explain the purpose of this phrase.

Bureau code

A commentator made the observation that insurers are licensed in Pennsylvania, not "authorized to provide services." The Department should review this definition to make sure it accurately describes valid insurers in Pennsylvania.

CCO – Coordinated Care Organization

Section 109 of the Act (77 P.S. § 29) also requires a CCO to be licensed in Pennsylvania. This requirement should be added to the regulatory definition.

Charge master

Commentators found the amendments objectionable. One commentator stated the definition is now wrong because a hospital charge master is a provider's listing of current charges for services provided to its patients; it is not a list of cost-based reimbursable providers and rates of reimbursement. Another commentator believes the definition is now unclear because it does not recognize that providers are reimbursed different amounts by different payers. The Department should explain why the definition is being amended and why the amendments are appropriate.

CPT-4

This term is defined in existing regulation. However, the proposed regulation uses the term "CPT" which is not consistent with the existing definition. The incorrect term is used in the definition of "Downcode" and throughout the proposed amendments to Sections 127.103 to 127.108. The defined term "CPT-4" should be used throughout the regulation.

Health care provider

The House Labor Relations Committee (House Committee) questioned whether entities that perform cost-containment services on behalf of providers, including third-party administrators, bill review companies and billing entities, would be included in this definition. We concur and also question whether rehabilitation facilities should be added to the definition.

Insurer

The amendment to change "workmen's" to "workers'" is inconsistent with Section 109 of the Act (77 P.S. § 29). Why is this amendment appropriate?

Medical records

We have two concerns. First, the language of the definition, which includes information that "completely reflects the evaluation and treatment of the patient" is too broad. Language should be added to limit information to medical information minimally necessary and authorized under the Act.

Second, the definition is limited to "written information." If the Department intends to include electronic records, this definition should be amended accordingly.

Medical reports

This definition should include physical findings and prognosis as required by Section 127.203(d)(4).

Provider under review

Commentators are concerned that this definition may exclude providers who should get notice to participate in a utilization review (UR) or Peer Review. One commentator questioned whether this definition covered services provided as a result of a referral. The Department should review

this definition and explain how it covers all parties who should get notice of a UR or Peer Review.

Usual and customary charge

Several commentators questioned how the database related to this definition would be developed and implemented. Since no explanation or description of this database was provided in the Preamble, we agree. The General Assembly, Standing Committees, this Commission and public have not been given an opportunity to review this fundamental provision of the regulation. Furthermore, we question the validity of the Department's response in the Regulatory Analysis Form to Question 17 that "no significant costs are anticipated." The Department must provide a detailed description of the database so that its economic impact can be understood and evaluated in regard to the public interest.

Subchapter B. MEDICAL FEES AND FEE REVIEW CALCULATIONS

7. Section 127.109. Supplies and services not covered by fee schedule. – Reasonableness; Economic impact.

Commentators have stated that identifying supplies will be burdensome. Others believe the forms are not designed to provide that much data. The Department should explain how the benefits imposed by this provision outweigh the costs. In addition, the Department should explain how the information can be put on existing forms.

8. Section 127.111a. Inpatient acute care providers--DRG updates. – Consistency with statute; Economic impact; Reasonableness.

Consistency with statute

Section 306(f.1)(3)(ii) of the Act (77 P.S. § 531(3)(ii)) specifies that commencing January 1, 1995, the maximum allowance for a healthcare service shall be updated equal to the percentage change in the Statewide average weekly wage. Under Section 306(f.1)(3)(i) of the Act (77 P.S. § 531(3)(i)), the Insurance Commissioner can adopt a new allowance by regulation if the Insurance Commissioner determines an allowance is not reasonable.

This statutory mechanism is used in Subsections (b) and (g) via the application of the Statewide average weekly wage. However, Subsections (a), (c), (e) and (f) use DRG rates rather than the Statewide average weekly wage. Subsection (d) specifies that payments may not be updated based on the Statewide average weekly wage. The Department should justify Subsections (a), (c), (d), (e) and (f) since they are not consistent with the statute.

Economic impact and Reasonableness

If the Department demonstrates that this section is consistent with statute, commentators believe that the differing mechanisms to update rates will be difficult to administer and will raise administrative costs. The Department should explain why it is reasonable to use these mechanisms and the economic impact that results from the amendments proposed in this section.

9. Section 127.114. Inpatient acute care providers--outliers. – Reasonableness.

Subsection (a) $36,000

Several commentators believe the inclusion of the specific dollar amount of $36,000 is not appropriate because Medicare changes the amount annually. The Department should further explain why this is the appropriate amount to add to the regulation.

10. Section 127.117. Outpatient acute care providers, specialty hospitals and other cost-reimbursed providers. – Consistency with statute; Economic impact; Reasonableness; Need.

Consistency with statute

Section 306(f.1)(3)(ii) of the Act (77 P.S. § 531(3)(ii)) specifies that commencing January 1, 1995, the maximum allowance for a healthcare service shall be updated equal to the percentage change in the Statewide average weekly wage. Under Section 306(f.1)(3)(i) of the Act (77 P.S. § 531(3)(i)), the Insurance Commissioner can adopt a new allowance by regulation if the Insurance Commissioner determines an allowance is not reasonable.

This statutory mechanism is used in Subsection (b) via the application of the Statewide average weekly wage but is modified by Subsection (c). Subsection (d) specifies that payments may not be updated based on the Statewide average weekly wage. Subsection (e) uses the ratio of cost-to-charges to update costs. The Department should explain how Subsections (b), (c) and (d) are consistent with the statute.

Economic impact and Reasonableness

If the Department demonstrates this section is consistent with statute, commentators believe that the differing mechanisms to update rates will be difficult to administer and will raise administrative costs. Other commentators believe the mechanisms proposed will not support the costs of treatment. The Department should explain why it is reasonable to use different mechanisms and the economic impact that will result from the amendments proposed in this section.

Subsection (c)

Some providers commented that the change from service codes to service descriptors will introduce confusion and inefficiency. Further, revenue codes are not always used in existing systems. An insurer commented that this subsection is confusing regarding what constitutes the appropriate revenue code. The Department should explain the need for the changes proposed in this subsection and the costs associated with implementing this provision.

Subsection (g)

Some providers were confused with what payment would be based upon. Further, some providers believe that blending the basis for payments will create an even heavier administrative burden. The Department should explain the need for the changes proposed in this subsection and

the costs associated with implementing this provision.

Also, this subsection ends with "...according to the procedures established under this chapter for Medicare Part B services." A specific cross-reference should be added.

Subsections (g) and (h)

An insurer commented that these subsections presume timely and accurate submission of information from hospitals which has been a problem under current regulation. A provider commented that the 30-day timeframe specified in Subsection (h) is too short. The Department should review these subsections and explain why the 30-day requirement is reasonable and what happens if it is not met.

11. Sections 127.120 to 127.125 – Economic Impact.

"Updated annually by the percentage change in the Statewide average weekly wage"

A similar provision was added to each of these sections to freeze payments as of December 31, 1994, and update them using the Statewide average weekly wage. The Department should further explain why these provisions are being added at this point and their economic impact.

12. Section 127.125. ASCs. – Need; Economic impact.

Subsection (a)

The Department is adding the requirement for ambulatory surgical centers to be licensed by the Department of Health. The Department needs to explain why this provision is needed at this point in time and its economic impact.

13. Section 127.130. Special reports. – Economic impact; Clarity.

What is a "special report"?

The regulation does not define what a "special report" is. To the contrary, Subsections (b) and (c) state what is not a special report. We recommend either defining the term "special report" in § 127.3, relating to definitions, or stating within this section what constitutes a special report.

Subsection (b)

The provision that limits payments for special reports to 80% of the provider's usual and customary charge is being eliminated. The Department states this provision is being deleted "because special reports are not generally a component of medical treatment and, by definition, provide greater information than required under the act." Insurers commented that deleting this cap will increase costs. The Department should further explain why this provision is being deleted and how the deletion will impact costs under its jurisdiction.

14. Section 127.131. Payments for prescription drugs and pharmaceuticals--generally. – Reasonableness; Feasibility.

Subsection (a)

Commentators question the use of the "Drug Topics Redbook." They believe the Drug Topics Redbook is slow in providing updates and recommend use of "Medispan." They question what edition of the Drug Topics Redbook to use since there are interim revisions to the annual edition. The commentators also question whether to use the print edition, software edition or database editions. The Department should respond to these concerns and explain why the selection of the Drug Topics Redbook is appropriate.

An insurer suggested requiring pharmacists and physicians to supply the National Drug Classification Code so the average wholesale price can be accurately determined. Would this improve processing of payments?

15. Section 127.132. Payments for prescription drugs and pharmaceuticals--direct payment. – Need; Protection of the public; Economic impact; Reasonableness.

Subsection (b)

The House Committee is concerned that the language "except as provided in Subchapter D" may preclude an injured worker from going to the pharmacy used for a substantial period of time. The House Committee also asks if a carrier would deny payment to a provider if the provider is not on the injured employee's list. We have the same concerns. This provision could impose hardship and expense on an injured person who has difficulty getting to an alternate pharmacy. The Department should explain why this amendment is needed and how it would impact both an injured employee and a provider who is not on the list but dispenses pharmaceuticals to the employee.

16. Section 127.133. Payments for prescription drugs and pharmaceuticals--effect of denial of coverage by insurers. – Need; Clarity.

As amended, this provision simply guides insurers to comply with "the act and this chapter." It is not clear when or how this provision would apply. We recommend adding language to this section to explain its applicability. We also note that the title of this section does not reflect the content.

17. Section 127.134. Payments for prescription drugs and pharmaceuticals--ancillary services of providers. – Need.

A commentator states that Subsection (a) has been obsolete since 1995 and should be deleted. Is this provision obsolete?

BILLING TRANSACTIONS

18. Section 127.201. Medical bills generally. – Reasonableness; Feasibility.

Subsection (c)

As this subsection is written, the phrase "...and all applicable records required under §127.203...within 90 days...." is inconsistent with the 10-day and monthly medical reporting requirements in Section 127.203(a). We recommend deleting the phrase "and all applicable records required under §127.203" from this subsection.

Many providers commented that they believe the 90-day billing requirement should be 180 days. They also explain that it is often difficult to connect an injury to a work-related incident within 90 days. One commentator further suggests adding a provision that allows physicians to directly bill a patient after the 180 days when the patient fails to tell the provider that the injury occurred at work. On the other hand, several insurers commented that they believe 90 days is needed, practical and fair. We recommend that the Department explain why the 90-day billing requirement is reasonable, feasible and appropriate.

19. Section 127.203. Medical bills--submission of medical documentation. – Protection of the public; Need; Reasonableness.

Subsection (d)

Paragraph (1) is a broad requirement for the provider to provide "information on the employee's history." This could be interpreted to require irrelevant information. We recommend limiting this requirement to information such as medical history or information on the injury.

20. Section 127.204. Fragmenting or unbundling of charges by providers. – Feasibility.

An insurer commented that the Correct Coding Initiative is too limiting and that other programs such as Medicare guidelines provide more detail. The Department should explain why the Correct Coding Initiative is appropriate.

REVIEW OF MEDICAL FEE DISPUTES

21. Section 127.253. Application for fee review--documents required generally. – Economic impact; Reasonableness; Clarity.

Subsection (a)

Paragraph (1) would require the submittal of the first bill sent to the insurer. Since there may be several bills, the Department should limit this information to the first disputed bill.

22. Section 127.255. Premature applications for fee review. – Reasonableness.

Subsection (a)

Paragraph (2) requires the insurer to "accurately" inform the Bureau. What standard is imposed

by requiring the insurer to "accurately" inform the Bureau? The word "accurately" should be deleted unless the Department can provide standards the insurer must meet for an accurate submittal.

23. Section 127.256. Administrative decision and order on an application for fee review. – Reasonableness; Clarity.

Subsection (a)

As noted in our general comment on timeframes and Section 435(a) of the Act (77 P.S. § 991(a)), we recommend that the Department retain the requirement to "render an administrative decision within 30 days."

24. Section 127.260. Fee review adjudications. – Reasonableness.

Subsection (a)

As noted in our general comment on timeframes and Section 435(a) of the Act (77 P.S. § 991(a)), we recommend that the Department retain the requirement for the hearing officer to issue a decision and order within 90 days.

Subchapter D. EMPLOYER LIST OF DESIGNATED PROVIDERS

25. Section 127.752. Contents of list of designated providers. – Consistency with statute; Clarity.

Subsections (b) and (e) specify requirements regarding a "single point of contact." We have two concerns. First, commentators believe the Department has no authority for these provisions. The Department should explain how these subsections are consistent with the Act, including Section 306(f.1)(1). Second, these subsections are vague because the term "single point of contact" is not defined.

Subchapter E. MEDICAL TREATMENT REVIEW

UR--GENERAL REQUIREMENTS

26. Section 127.803. Assignment of cases to UROs. – Need; Reasonableness; Clarity.

Subsection (a) states the following: "The Bureau will assign requests for UR to authorized UROs." Numerous commentators are concerned that this provision does not indicate that the assignments will be made randomly. This differs from existing regulation § 127.403, pertaining to assignment of cases to UROs by the Bureau. How will the Bureau assign URs to UROs?

27. Section 127.805. Requests for UR--filing and service. – Need; Clarity.

Under Subsection (e), the Bureau will not accept and will return UR requests when it can determine that any of six enumerated circumstances occurred. In order for the party requesting the UR to know why the UR request was denied, we recommend that the final-form regulation

include a provision that requires the Department to give reasons why the UR was returned.

28. Section 127.806. Requests for UR--assignment by the Bureau. - Need; Clarity.

Subsection (a)

Similar to our concern on § 127.803, how will the Bureau assign URs to UROs?

Subsection (b)

This subsection requires the Bureau to notify certain parties of the assignment of the UR. How long will the Bureau have to notify the affected parties? This should be included in the final-form regulation.

29. Section 127.807. Requests for UR--reassignment. – Clarity.

Subsection (b)

Under this subsection, a URO may not "directly" reassign a request for UR to another URO. Can a URO indirectly reassign a request for UR to another URO? If not, the term "directly" should be deleted.

Subsection (d)

This subsection states the Notice of Assignment from the Bureau to the URO shall be deemed received on the date the Bureau transmits notice by "electronic means or by facsimile." If a URO has a conflict of interest under § 127.808, can the URO return the assignment via electronic means or facsimile?

30. Section 127.809. Requests for UR--withdrawal. – Consistency with statute; Reasonableness; Clarity.

Subsection (b)

This subsection requires the Bureau to "promptly" notify the URO of a withdrawal. The term "promptly" is vague. It should be replaced with a specific number of days.

Subsection (c)

This subsection requires the insurer to pay the costs for the withdrawn UR. One insurer believes this is unreasonable whereas another believes this is contrary to Section 306(f.1)(6)(iii) of the Act (77 P.S. § 531(6)), which provides that the employer or the insurer shall pay the cost of the UR. The Department should explain why this provision is reasonable and consistent with statute.

UR—PRECERTIFICATION

31. UR - Precertification Sections 127.821 to 127.825. – Consistency with statute; Need; Economic impact.

Commentators argue that precertification is not in the Act. They further believe that precertification adds another layer of procedure to an already cumbersome process. The Department should explain how the precertification provisions are consistent with the Act, why they are needed, and the costs imposed by them.

32. Section 127.821. Precertification. – Consistency with statute; Need.

This section states that an employee or provider may seek precertification. Precertification is defined under § 127.3 as, "Prospective review, sought by an employee or provider, to determine whether future treatment is reasonable and necessary." Prospective review is defined in the same section as, "UR of proposed treatment that is conducted before the treatment is provided." Section 306(f.1)(6)(i) of the Act (77 P.S. § 531(6)(i)) states that UR may be requested by an employee, employer or *insurer*. It also states that the Department will authorize UROs to perform UR.

We have two concerns. First, since the Act allows an employee, employer or insurer to request UR, why is it proper for the definition of "precertification" and Subsection (a) to state only "an employee or provider may seek precertification"?

Second, since precertification is prospective review, it would have to be done by a URO. What is the Department's statutory authority for allowing insurers to determine the reasonableness and necessity of proposed treatment under the precertification process?

33. Section 127.822. Precertification--insurer obligations. – Clarity.

Subsection (a)(2) requires an insurer to complete and return a form to the employee *and* provider within 10 days upon which the form was mailed. It allows a provider or employee to evidence the date of mailing through the use of the United States Postal Service Form 3817 (Proof of mailing). We have four concerns. First, is the 10-day time period the insurer has to complete and return the form reasonable? Second, what is meant by "return"? Must the employee or provider be in receipt of the completed form within 10 days, or must the completed form be deposited in the mail within 10 days? Third, can employees and providers use private or common carriers to submit these forms? Also, what if there is no postmark? The regulation should specify how timeframes will be determined if a carrier other than the US Postal Service is used. Fourth, Subsection (c) states that if the insurer has failed to return the form to the employee *or* provider, the insurer shall pay for treatment. This differs from the requirement in Subsection (a)(2) which requires the insurer to respond to the employee *and* provider. These provisions should be reconciled.

34. Section 127.824. Precertification-employee-filed requests. – Clarity.

Subsection (a) provides a 10-day time period for a provider to comply with a request from a URO. Does the 10-day time period begin the day the request was sent or the day the request was

received? This needs to be specifically addressed because Subsection (b) allows treatment to be determined unreasonable and unnecessary if the response to the request is not timely.

35. Section 127.825. Assignment of proper requests for precertification. – Clarity.

This section pertains to Bureau assignment of precertification requests for URO. The final-form regulation should include a provision that states within what timeframe the Bureau will assign the request for precertification.

PROSPECTIVE, CONCURRENT AND RETROSPECTIVE UR

36. Section 127.831. Prospective, concurrent and retrospective UR--insurer requests. – Clarity.

Under Subsection(a), an insurer may request review of current or prospective treatment. The title of this section includes retrospective UR. Why isn't review of retrospective treatment addressed in this section?

REQUESTS FOR UR--RECERTIFICATION AND REDETERMINATION

36. Section 127.842. Requests for UR--redetermination. – Protection of the public health, safety and welfare; Clarity.

This section allows an employee or provider, who was a party to the determination that found prospective treatment to be unreasonable or unnecessary, to request redetermination. This section lacks specific timeframes to be followed by the affected parties. We recommend that timeframes be added to the final-form regulation.

Subsection (d)

This subsection states, in part, the following: "The assigned reviewer will determine if the employee's medical condition has changed and the treatment under review is now reasonable and necessary." The Department should explain how a reviewer is qualified to determine if an employee's medical condition has changed.

URO OPERATIONS

37. Section 127.851. Requesting and providing medical records. – Clarity.

Subsection (b)

This subsection references "a complete set of records related to the work injury." Subsections (c) and (d) reference "medical records." The term "medical records" is defined under §127.3 and should be used in Subsection (b).

In addition, this subsection requires UROs to request records from the provider via certified mail. Why aren't other methods of request, such as fax, electronic submission, or private or common carrier allowed?

Subsections (c) and (d)

Commentators have noted that the timeframes for mailing medical records under these subsections are too short. The Department should explain why these timeframes are appropriate and reasonable.

38. Section 127.852. Scope of review of UROs. – Clarity.

Subsection (a) states, "UROs shall decide only the reasonableness and necessity of the treatment under review." This conflicts with §§ 127.833 and 127.842, which allow the reviewer to determine whether or not a change in the workers condition has occurred. The Department should reconcile these provisions.

39. Section 127.854. Obtaining medical records--provider under review. – Need; Clarity.

Subsection (a)

This subsection requires UROs to request records from providers under review in writing and via "certified mail, return receipt requested." We have two questions. First, can UROs use private or common carriers to request records from providers? Second, current § 127.459 (relating to obtaining medical records – provider under review), allows UROs to request records from the provider under review by phone. Why was this option deleted?

Subsection (b)

This subsection states:

> "The provider under review, or his agent, shall sign a verification stating that to the best of the provider's knowledge, the medical records provided constitute the true and complete medical record as it relates to the employee's work injury. When records are not accompanied by the appropriate verification, the URO shall return the records to the provider, may not consider the records in issuing its determination, and shall disregard the fact that the records were forwarded to the URO."

The Preamble does not explain the need for this provision. Why is it being added?

40. Section 127.855. Employee personal statement. – Reasonableness; Clarity.

Under this section, an employee may submit a statement regarding the reasonableness and necessity of the treatment under review. We have three questions. First, can the statement be prepared by someone other that the employee? Second, Subsection (c) limits what can be included with the statement. Why is the employee prohibited from submitting "enclosures, attachments or documentation"? Finally, Subsection (c)(2) prohibits discussion of and independent medical examination or impairment rating evaluation. Why is this prohibition needed?

41. Section 127.856. Insurer submission of studies. – Reasonableness.

This section allows an insurer to submit certain documentation which is relevant to the reasonableness and necessity of the treatment under review to the URO. Commentators have raised two questions with this provision. First, is there a chance to rebut the submittals with other studies? Second, and similar to our concern above, why are employees and UROs prohibited from submitting their own documentation?

42. Section 127.857. Obtaining medical records--other treating providers. – Reasonableness.

Existing regulations at §127.460 allowed records to be requested in writing or by phone. This subsection requires UROs to request medical records from other treating providers in writing. Why is the option to request records by phone being deleted?

43. Section 127.858. Obtaining medical records--independent medical exams. – Need; Reasonableness.

This section states:

> "A URO may not request and a party may not supply reports of examinations or evaluations performed at the request of an insurer, employee or attorney for the purposes of litigation. Only the medical records of actual treating providers, and the personal statement and studies referenced in §§ 127.855 and 127.856 (relating to employee personal statement; and insurer submission of studies), may be requested by or supplied to a URO."

The insurance industry, a URO and a medical rehabilitation facility have commented that this provision is unreasonable. What is the need for this provision?

44. Section 127.862. Requests for UR--deadline for URO determination. – Consistency with statute; Need; Reasonableness; Clarity.

Subsection (a)

This subsection states the following: "A request for UR shall be deemed complete upon the URO's receipt of the medical records or 18 days from the date of the notice of assignment, whichever is earlier." Commentators believe this timeframe is too short. We note that current regulation § 127.465 provides a 35-day timeframe. Why has the timeframe been shortened?

In addition, the phrase "deemed complete" suggests a request is complete even if records are missing. Must a URO consider a request complete if some of the medical records were not provided?

Subsection (b)

This subsection states that a URO shall complete its review and render its determination within 20 days of a completed request for UR. Section 306(f.1)(6)(ii) of the Act (77 P.S. § 531(6)(ii))

states the following: "The utilization review organization shall issue a written report of its findings and conclusions within thirty (30) days of a request." Therefore, Subsection (b) should be amended to reflect the 30-day statutory time period.

Subsection (c)

Commentators stated that the 10-day timeframe for a URO to forward all of the required information to the reviewer under this subsection is unreasonable. The Department should consider extending this timeframe.

45. Section 127.863. Assignment of UR request to reviewer. – Consistency with statute.

Subsection (a) requires the UR reviewer to be of the "same profession and having the same specialty as the providers under review." Section 306(f.1)(6)(i) of the Act (77 P.S. § 531(6)(ii)) requires the reviewer to be "in the same profession and having the same **or similar** specialty as that of the provider of the treatment under review." (Emphasis added.) This subsection should be amended to be consistent with the Act.

UR--PETITION FOR REVIEW

46. Section 127.903. Petition for review--notice of assignment and service. – Clarity.

This section requires the Bureau to assign a petition for review to a workers' compensation judge and to mail the notice of assignment to certain parties. The section lacks a timeframe for mailing the notice. We recommend that timeframes be included in the final-form regulation.

47. Section 127.906. Petition for review by Bureau--hearing and evidence. – Clarity.

Subsection (d) states that a workers' compensation judge may disregard evidence offered by any party who has failed to respond to a UROs request for records in the same UR matter as set forth in §127.861. Section 127.861(c) prohibits a provider that fails, without reasonable cause, to supply records under this section, to introduce evidence regarding the reasonableness and necessity of the treatment under appeal. Would a workers' compensation judge be allowed to consider evidence from a provider that is barred from submitting evidence under § 127.861(c)?

PEER REVIEW

48. Section 127.1005. Peer review--assignment by the Bureau. - Implementation procedures; Clarity.

Subsection (a)

This subsection states: "The Bureau will assign a properly filed request for peer review to an authorized PRO." We have two concerns. First, within what timeframe will the Bureau assign a peer review to a PRO? Second, numerous commentators are concerned that this provision does not indicate that the assignments will be made randomly. This differs from existing regulation § 127.605, pertaining to peer review-assignment by the Bureau. How will the Bureau assign peer reviews to PROs?

Subsection (b)

This subsection requires the Bureau to notify certain parties of the assignment of the peer review. How long will the Bureau have to notify the affected parties? This should be included in the final-form regulation.

49. Section 127.1006. Peer review--reassignment. – Clarity.

Subsection (d) states the Notice of Assignment from the Bureau to the PRO shall be deemed received on the date the Bureau transmits notice by "electronic means or by facsimile." If a PRO has a conflict of interest under § 127.1007, can the PRO return the assignment via electronic means or facsimile?

50. Section 127.1010. Obtaining medical records--independent medical exams. – Need.

The Preamble provides no explanation for the prohibition of reports of examinations or evaluations performed at the request of an insurer, employee or attorney for the purposes of litigation. Why is this prohibition needed?

51. Section 127.1012. Assignment of peer review request to reviewer by PRO. – Clarity.

What is meant by "same profession and having the same specialty as the providers under review?" Is the same board certification needed?

52. Section 127.1013. Duties of reviewers--generally. – Reasonableness.

Existing Section 127.616. (relating to duties of reviewers—consultation with provider under review.) states:

> The PRO shall give the provider under review written notice of the opportunity to discuss treatment decisions with the reviewer. The reviewer shall initiate discussions with the provider under review when such a discussion will assist the reviewer in reaching a determination. If the provider under review declines to discuss treatment decisions with the reviewer, a determination shall be made in the absence of such a discussion.

Why isn't this provision included in Subchapter E?

53. Section 127.1015. Duties of reviewers--finality of decisions. – Need; Reasonableness.

Under Subsection (a), a reviewer may not render advisory opinions on whether additional diagnostic tests are needed. The Preamble provides no explanation for this prohibition. Why can't a reviewer advise that additional diagnostic tests are needed?

URO/PRO AUTHORIZATION

54. Section 127.1051. Authorization of UROs/PROs. – Need; Reasonableness; Implementation procedures; Protection of the public health, safety and welfare; Clarity.

The Department is deleting its procedures for authorizing UROs and PROs found under existing regulations at §§ 127.651 – 127.670. Those procedures are being replaced with § 127.1051. This new section will allow the Bureau to award contracts under 62 Pa.C.S (relating to Commonwealth Procurement Code) to perform reviews under this chapter. Contracts will be awarded on a competitive sealed basis through a request for proposal issued by the Bureau. The Request for Proposal (RFP) will set forth the specific requirements the proposal must meet.

Commentators have raised numerous concerns with this change. Concerns ranging from how the new procedure will be administered to the statutory authority of the Department to authorize UROs and PROs through the RFP process have been expressed.

We believe the Department has failed to explain why this change is being made, how it will provide a quality system of review and how it will be implemented. The Preamble to the final-form regulation should explain what the need for this change is, how it will improve upon the current procedure and how the new authorization procedures will be implemented.

Facsimile Cover Sheet

Kristine M. Shomper
Administrative Officer

Phone: (717) 783-5419
Fax #: (717) 783-2664
E-mail: kriss@irrc.state.pa.us
Website: www.irrc.state.pa.us

INDEPENDENT REGULATORY REVIEW COMMISSION
333 MARKET STREET, 14TH FLOOR, HARRISBURG, PA 17101

To: Neil E. Cashman, Jr.
Agency: Department of Labor & Industry
Phone: (717) 787-5087
Fax: (717) 783-5225
Date: **August 9, 2006**
Pages: **21**

Comments: We are submitting the Independent Regulatory Review Commission's comments on the Department of Labor & Industry's regulation #12-72 (IRRC #2542). Upon receipt, please sign below and return to me immediately at our fax number 783-2664. We have sent the original through interdepartmental mail. You should expect delivery in a few days. Thank you.

Accepted by: _____ **Date:** 8/9/06

FaxS