THE DOCTOR'S GUIDE TO PENNSYLVANIA WORKERS' COMPENSATION BILLING

FENNER & BOLES, LLC

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Prepared By

Attorneys

At Fenner & Boles, each of the partners has more than 25 years of experience helping injured people and their families. In the Philadelphia area and throughout Pennsylvania, our law firm is well regarded by former clients as well as other attorneys.

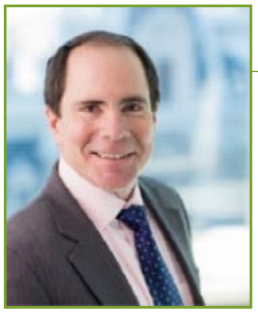
If you are being given the run-around about workers' compensation benefits, if you have been denied Social Security Disability or Long Term Disability benefits, or if you have been injured in a car accident or through someone else's negligence, talk to one of our lawyers.

The consultation is free. Find out what we can do for you.

Diane Fenner

Diane Fenner graduated from the University of Pennsylvania Law School. She received her Bachelor of Arts degree with honors from Barnard College, and also has a Ph.D. in psychology from Columbia University. Diane has been practicing law since 1983. After 4 years at the prestigious Philadelphia-based defense firm of Pepper Hamilton, Diane switched to a practice exclusively devoted to the representation of injured individuals. As such, she has practiced in various areas of personal injury, including medical malpractice, automobile accidents, premises liability, and product liability.

At the present time, her Philadelphia practice is devoted primarily to workers' compensation matters, where she represents both injured workers and medical providers who are denied payment for their treatment. In addition, she has a national practice specializing in the representation of people injured as a result of pharmaceutical products. She is the co-author of a chapter in ATLA's Litigating Tort Cases entitled "Drugs and Medical Devises," and was involved extensively in Hormone Therapy (Prempro) litigation. Diane also has the following qualifications: Treasurer, Workers' Compensation Section of the Philadelphia Bar Association, Certified Specialist in Workers' Compensation, and Lecturer, Philadelphia Bar Association.



Gregory Boles

Gregory Boles is a graduate of Georgetown University and a graduate of Villanova Law School. Before opening his own practice in 2000, Greg was a partner in Willig, Williams & Davidson, where his practice was devoted exclusively to the representation of injured workers. He is the author of "Consumer's Guide to Pennsylvania Workers' Compensation" and "Caregiver's Guide to Pennsylvania Workers' Compensation Billing." Greg has written extensively on Pennsylvania workers' compensation and has lec-tured before attorneys, labor unions and advocacy groups for the disabled. Greg also has the following qualifications: Certified Specialist in Workers' Compensation and Super Lawyer since 2007.

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What are medical caregivers entitled to recover under the Pennsylvania Worker's Compensation Act?

The Workers' Compensation Act states that payment of medical expenses "shall be no more than 113% of the applicable Medicare reimbursement mechanism or, if no such reimbursement mechanism exists for a particular service, payment shall be at 80% of the amount most often charged for the service by similar medical providers within a given geographic area." (See 77 P.S. Section 531(3)(i) and (vi).

Who is responsible for calculating the statutory fee cap on medical bills submitted for payment?

Insurers are responsible for this calculation.

Are there any exceptions to the fee caps?

Yes. If a caregiver provides acute care to patients with immediately life-threatening or urgent injuries in accredited trauma centers or burn facilities, payment for such services shall be the usual and customary rate.

What must an insurer pay for prescription medication?

Reimbursement of prescriptions is limited to 110% of the average wholesale price of the product. Pharmacists are not permitted to bill the patient for the difference between the pharmacist's charge and the allowed amount.

What if a patient pays more than the amount allowed under the Act for prescription medication?

If an injured employee pays more than the amount allowed by the Act because the insurer initially denies the claim denies liability to pay for the prescription, the insurer must reimburse the employee for the actual cost of the prescription drugs, once liability has been admitted or determined. 34 Pa. Code Section 127.133.

What must a medical provider do to obtain payment of medical bills?

The Act requires providers to file periodic medical reports with the employers on Bureau Form LIBC9 (see Appendix "A" for a copy of this form.) The bills must be submitted on the appropriate HCVA form. Unless the bills are filed with the required medical reports, the employer or its insurer is not obligated to pay for the treatment billed.

Once a bill has been submitted, how much time does the insurance company have to make payment to a provider?

The insurance company must pay bills within thirty days of receipt of the bill and report.

How does an insurance company challenge payment of medical bills?

The Act allows insurers to file a utilization review petition to challenge the reasonableness and/or necessity of the provider's underlying treatment. The petition must be filed within thirty days of receipt of the provider's bills and records, although such a petition applies prospectively to treatment rendered by the provider after the date of filing of the petition.

What happens after an insurance company files the utilization review petition?

The petition will be assigned to a utilization review organization, which is supposed to issue a report within thirty days. Notice of assignment of the utilization review petition will be provided to the caregiver.

What should a medical provider do in the event that a utilization review is filed?

Once the utilization review is assigned to a utilization review organization, copies of the medical bills and records should be submitted to the organization promptly. The failure to supply them within thirty days of request will ordinarily result in an adverse decision.

May the patient submit a statement concerning the medical treatment in question?

Yes. If the patient wishes, he or she can forward to the utilization review organization a statement concerning the treatment provided.

Who pays for the cost of utilization review?

The employer or insurer is responsible for payment.

What happens after the petition is assigned and medical records are forwarded to the utilization review organization?

The utilization review organization will issue a report on the treatment under review. If all or part of the treatment is found to be unreasonable or unnecessary, the employer will be relieved of the obligation to pay all or part of the medical bills. If all treatment is found reasonable the insurer must pay for all treatment.

What can a caregiver do if it has been affected by an adverse report by a utilization review organization?

If a party disagrees with the utilization review report, the party must file an appeal within thirty days of receipt. The appeal forms should be sent with the report. Free forms can be obtained by calling (866) 772-0700.

If the caregiver's treatment is found to be reasonable, may the employer or insurance company avoid payment by filing a petition for review of the decision?

No. While such an appeal is pending, the insurance company must pay for treatment which has been determined to be reasonable.

What happens when an appeal is filed?

An appeal is assigned to a workers' compensation judge. The burden is always on the employer to establish that the medical treatment is not reasonable, no matter which party prevailed at the utilization review level.

May an insurance company challenge the reasonableness and necessity of medical treatment while an injured employee is pursuing a claim before a Worker's Compensation Judge?

Yes. An employer is entitled to file a peer review petition while a claim is pending. In all other ways, such a petition will be handled like a utilization review petition.

May a utilization review organization decide questions of causation and disability?

No.

What can a medical provider do if it believes that the amount paid by the insurance company is incorrect, or that payment has not been timely?

A medical provider has the right to file an application for fee review concerning the amount and/or timeliness of an employer's or insurer's payment of their bills. Such a petition must be filed within thirty days following notification of disputes concerning their bills, or ninety days following the original billing date. A copy of the form is attached as Exhibit " ".

What documentation must be submitted with an application for fee review?

Providers reimbursed under the Medicare Part B Program must submit the applicable medical billing form, the required medical report form, together with office notes and documentation supporting the procedures performed or services rendered, and an explanation of benefits, if available. If a provider is reimbursed under the Medicare Part A Program, the application must be filed with the applicable Medicare billing form, the most of program reimbursement, the most recently audited Medicare cost report, the required medical report form, together with documentation supporting the procedure performed or services rendered, and the explanation of benefits, if available. Although it is not set forth in the regulations, in all cases the application for fee review should be accompanied by a letter on the provider's stationery, signed by someone authorized to act on behalf of the provider, certifying that the bills have been properly submitted and are more than 33 days overdue. A suggested form is attached as Exhibit " ".

How long does the Bureau have to issue a decision once it has received the required documentation?

The Bureau is supposed to issue an administrative decision within thirty days. Prior to rendering the decision, however, the Bureau must investigate the matter and contact the insurer to obtain its response to the application.

Does a provider or insurer have the right to contest an adverse administrative decision?

Yes. The party contesting the administrative decision must file an original and seven copies of a written request for hearing with the Bureau within thirty days of the date the decision is made on the fee review. A copy of the request for hearing must be served upon the prevailing party in the fee dispute. A notice certifying that a copy of the request for hearing has been mailed to the prevailing party, setting forth the date of mailing, must also be provided at the time the request is filed. A copy of the hearing request is attached as Exhibit " " and a suggested notice of service is attached as Exhibit " ".

What happens when an appeal of a decision on a fee review is filed?

The Bureau will assign the request for a hearing to a hearing officer, who will schedule a hearing.

If the insurance company has denied responsibility for the employee's work injury, may the medical provider submit the bills to the employee's health insurance carrier?

Yes. Insurance Department regulations impose upon health insurers the obligation to pay bills when the workers' compensation insurance company has denied liability.

What should a provider do in order to obtain payment of bills by a health insurer?

The provider should submit to the health insurer the bills with a copy of the workers' compensation denial or other documentation demonstrating that the workers' compensation insurance company has denied responsibility for the bills.

Are ERISA Plans which provide medical coverage legally obligated to pay for medical treatment where the workers' compensation insurance company has denied coverage?

Injured employees frequently will have health coverage through a health and welfare fund administered by an employer, a union or both. If they are ERISA Plans, they are not subject to Pennsylvania Insurance Department regulations.

Many such plans allow for payment of medical bills that have been denied, but additional obligations may have to be met. In order to determine these obligations, the in-jured workmust contact the office that administers the plan.

Is a medical provider entitled to reimbursement for the cost of reproducing medical records?

Yes. Within thirty days of receiving medical records, the utilization review organization is obligated to reimburse the provider for record copying costs at the rate specified by Medicare and for actual postage costs. Reproduction of radiological films are to be reimbursed at the usual and customary charge.

May an insurer deny payment to a provider where the referring provider has a financial interest in the referral provider?

Yes. There are, however, referral arrangements that are allowed under the Safe Harbor Regulations promulgated under the Medicare and Medicaid Patient Program Protection Act, and the Stark Amendments to the Medicare Act.

What must an insurer do if it believes that a bill is in violation of referral standards?

Within thirty days of the receipt of the provider's bill and medical report, the insurer is required to supply a written explanation of benefits stating the basis for believing that the self-referral provision has been violated.

May a provider file an appeal where a bill has been denied on this basis?

Yes, a provider may file an Application for Fee Review with the Bureau of Workers' Compensation. In such a case, the insurer has the burden of proving by a preponderance of the evidence that a violation of the self-referral provisions has occurred.

Can a medical provider obtain copies of the applicable fee schedules?

Yes. The Part A and Part B fee schedules can be downloaded from the Labor and Industry site at the link http://www.portal.state.pa.us/portal/server.pt/community/fee_schedule/10424
Table I, which applies to in-patient treatment only, is not available on-line. In order to obtain Table I, you must contact the Bureau of Workers' Compensation by telephone at (717) 787-3486.

Is free legal assistance available if a dispute arises with the workers' compensation insurance carrier over medical bills?

Yes. Fenner & Boles provides free legal services to medical providers in disputes with workers' compensation insurance carriers. The law offices can be contacted toll-free at (866) 772-0700.