TESTIMONY OF THE

PENNSYLVANIA ORTHOPAEDIC SOCIETY
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HOUSE LABOR AND INDUSTRY COMMITTEE HB 1141

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Thank you Chairwoman Gingrich, Chairman Galloway and committee members for this opportunity to testify on HB 1441 PN 2794. I am James McGlynn, chairman of the Pennsylvania Orthopaedic Society's Workers' Compensation Committee. I appreciate your willingness to have me back before the committee and to hear our Society's views on this important legislation.

As you know, HB 1141 brings commonsense reforms to the Workers' Compensation (WC) system. For many years, the Pennsylvania Orthopaedic Society (POS) has worked with committee staff to craft legislation designed to clarify and enforce existing law. We are not seeking grand modifications to the WC statute. We are merely attempting to make the system work for injured workers and the healthcare providers who treat them. The POS is grateful that Representative Saylor has been our champion for the past two legislative sessions.

The POS is deeply involved in WC issues. From a medical professional viewpoint, orthopaedic surgeons treat more injured workers than any other type of physician. In addition, the patients we treat are often severely injured. We care deeply for our patients and we hope this legislation will enhance the patient/physician relationship.

HB 1141 is designed to correct important longstanding information access and reimbursement issues that have plagued medical professionals. The legislation represents commonsense changes that will streamline the processing of bills, prohibit reimbursement discounting without a bone fide contract and ensure timely payments to providers. I am sure you will agree that HB 1141 is reasonable in its approach to resolving these issues.

CREATION OF STANDING FOR PROVIDERS

Currently, providers do not have access to certain basic information about the injured worker's claim. Lack of this basic information -- the claim number, the description of the work-related injury and the injury for which the insurer will pay -- often leads to improper billing and administrative inefficiency for the insurer and the provider. This occurs because the WC law does not confer standing on providers to receive documents and forms pertaining to injured workers, even though providers are vital to the system.

You may believe that a work-related injury would be obvious to a physician, and it may be, but other ailments that are discovered in the course of examination and treatment may not be work-related. Generally speaking, we treat our patients as they present themselves and many times they may only

have a work-related injury. But in far too many cases, an injured worker will have both work-related injuries and non-work-related injuries, all of which an orthopaedic surgeon will treat. Without access to the description of injury for which the insurer has accepted liability, we may submit a WC bill for all treatments. Then begins the process of correction which is time-consuming for both providers and insurers.

HB1141 fixes this problem by allowing providers electronic access to appropriate data fields within Pennsylvania's WC Automation and Integration System. The injured worker's claim number and description of injury for which the insurer has accepted liability appear on the EDI First Report of Injury (LIBC 90). Provider access to this document simply makes commonsense.

MANDATE ON WORKERS' COMPENSATION INSURERS, EMPLOYERS, AND THEIR AGENTS TO ACCEPT BILLS ELECTRONICALLY

Obviously, access to the First Report of Injury will improve the accuracy of what provider's bill to WC carriers. Electronic billing will improve how we transmit bills to those insurers. Believe it or not, many WC carriers do not accept electronic billing. The statute does not mandate it and therefore we still must submit paper claims. We are well into the 21st Century and we still must use a 20th Century system. In contrast to electronic billing to Medicare and other payers, workers' compensation billing is cumbersome and costly to process—an expensive burden on both providers and insurers. Not only does the paper claims method add costs to the system for providers and insurers, it directly leads to another ill HB 1141 will correct – the lack of prompt payment. With mandated electronic billing, providers and insurers will save money; reimbursements will be processed faster; and corrections can be made in a timely fashion. Again, this is a commonsense improvement to the WC law.

BAN SILENT DISCOUNTING/COERCIVE SOLICITATION

In addition to improving these process issues, the POS asks that you correct certain practices of the insurer/employer community and their agents.

The WC provider reimbursement fee schedule is set in the statute. Pursuant to the law, the fee schedule is annually adjusted according to the average weekly wage. The statute only authorizes coordinated care organizations (CCOs) to deviate from the mandatory fee schedule; there are no

CCOs presently operating in Pennsylvania. Current law also allows insurers and employers to contract with third parties to perform case management.

There are two conditions under which providers may legally be paid at amounts less than the mandated fee schedule:

1) Providers may agree by contract to accept WC reimbursement that is less than the mandatory fee schedule by signing an agreement with an employer, insurer or their third party representative to participate in the insurer or employer's provider network.

2) Healthcare insurers routinely include "all products" clauses in the contracts signed by providers in their networks. This contractual relationship requires a physician to be a member of all of an insurer's product provider networks (health, auto, WC, Medicaid HMO, etc.) if the physician wants to be a member of any of the insurer's provider networks. Although physicians generally are dissatisfied with these arrangements, a contractual relationship exists, therefore, a WC fee schedule discount may occur.

Silent discounting occurs when a physician receives discounted WC reimbursements, but has no contractual relationship with the party that is providing the discounted reimbursements. In some cases, a third party directly works with a self-insured employer or insurer and literally sends a discounted payment to a physician on a take it or leave it basis. A physician is left to accept a discounted fee or fight a fee review dispute with a third party with whom the physician has no contractual relationship. Silent discounters essentially work outside the bounds of the WC statute.

The POS has no quarrel if a provider agrees by contract to accept reduced reimbursement. We firmly believe, however, that bona fide contracts must exist before discounted reimbursement can be offered. HB 1141's provision to ban silent discounting is a commonsense method to ensure that payors comply with the current law.

In a similar fashion, using facsimile and other means, providers are inappropriately coerced into accepting amounts different from the mandated fee schedule. Such coercive tactics include threats that providers will be eliminated from provider networks; will not otherwise receive WC patient referrals; or will accept discounts on all future payments should they agree to accept one discount for one injured worker's procedure. HB 1141's ban on coercive solicitation is a commonsense way to end this odious practice.

INCREASED INSURER PENALTIES

HB 1141 will increase penalties on payors who do not comply with the WC statute's prompt pay and fee schedule update provisions. Currently, the penalties are an inadequate incentive for insurers and others to fulfill their obligations under the law. Attorney Artz will go into further detail on these provisions, but suffice it for me to say, POS believes these provisions are commonsense reforms.

PROVIDER AND CASE MANAGEMENT DEFINITIONS

The workers' compensation statute requires that every employer healthcare panel must include at least six providers, three of whom must be physicians. Providers have found that employers sometimes list a "provider network organization" as a panel provider. Such organizations are not providers but rather are agents of the employer working to solicit providers into a network, often without a contract, and designed to drive injured workers into an employer-controlled provider network. Changing the definition of "Health Care Provider" in the Act corrects this problem by requiring that a provider performing healthcare services must have a Pennsylvania license to do so and must possess a valid NPI (National Provider Identifier).

Employers are permitted by statute to contract with any individual, partnership, association, or corporation to provide case management and coordination of services for injured workers. The POS believes it necessary to define case management according to national standards. Therefore, HB 1141 defines case management as case assessment; developing, implementing and coordinating a care plan with providers, the injured worker, and the injured worker's family; management of healthcare treatment and utilization control; referral to vocational rehabilitative services; and, planning for return to work. These case management activities contribute too optimum medical and cost-effective outcomes. I will defer to our fellow panelist from Procare for more detail on this issue.

CONCLUSION

In conclusion, the POS again thanks Rep. Saylor for leading the way for these commonsense reforms. We stand ready to work with the committee to move this important issue forward. Thank you for the opportunity to be here today.