Payment of Medical Bills – The Fee Review Process, Challenges, and Litigation

PANELISTS

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The Act Creates the Fee Review Process

- Provider-initiated review of the amount and/or timeliness of the payment of medical expenses.

- The Act created the Fee Review process. Section 306(f.1)(5), 777 P.S. §531(5).
  - …All payments to providers for treatment provided pursuant to this act shall be made within thirty (30) days of receipt of such bills and records unless the employer or insurer disputes the reasonableness or necessity of the treatment provided pursuant to paragraph (6)….

- The Medical Cost Containment Regulations are at 34 Pa. Code §127.1 through 127.755. The Regulations provide the parameters for Fee Reviews and Utilization Reviews and establish how providers must bill, how they must be reimbursed, and how they can dispute the amount and timeliness of payment.

Fee Reviews apply to Health Care Providers

- The Regulations apply to “Health care providers.”

- 34 Pa. Code § 127.3 defines health care provider:
  - A person, corporation, facility or institution licensed, or otherwise authorized, by the Commonwealth to provide health care services, including physicians, coordinated care organizations, hospitals, health care facilities, dentists, nurses, optometrists, podiatrists, physical therapists, psychologists, chiropractors, or pharmacists, and officers, employers or agents of the person acting in the course and scope of employment or agency related to health care services.

The Regulations address reimbursement

- How much can a Provider be paid?
  - Section 127.101-127.107: Medical fee caps for Medicare as well as how and which providers are subject to the Medicare fee schedule.
  - Section 127.102: Medical Fee Caps and Usual and Customary Charges. If a Medicare payment mechanism does not exist for the stated treatment, the reimbursement shall be at 80% of the usual and customary charge for the treatment in the geographical area where rendered or the actual charge, whichever is lower.
  - Section 127.107: Durable Medical Equipment and In-Home Infusion reimbursement.
  - Section 127.110 – 127.116: Inpatient Care.
  - Section 127.125: Ambulatory Surgery Centers.
  - Section 127.128: Trauma Centers and Burn Facilities.
  - Section 127.131-133: Prescription Drugs and Pharmaceuticals.

Bills and Medical Reports

- How are Bills submitted?
  - Bills should be submitted on the HCFA Form 1500 or the UB92 Form (or successor form). Section 127.201

- Are Medical Reports Required?
  - Providers who treat injured employees must submit periodic medical reports to the Employer, starting ten days after treatment begins and at least once a month thereafter. Section 127.203(a)

Time for Payment

- How long does Insurer have to pay or deny the bill?
  - 30 days after receipt of the bill and report.
    Section 127.208(a)
  - Insurer is deemed to have received the bill 3 days after mailing.
    Section 127.208(b)
  - Insurer must supply a written EOB paid. If a bill is denied, it must contain a written explanation.
    Section 127.209

Extending the time for payment

What lengthens the 30 days?

- If insurer requests additional information, that does not lengthen the 30 days for payment. Section 127.208(c)
- The 30 days is tolled if Insurer requests a UR. If the UR finds the treatment reasonable and necessary, payment is due even if Insurer files a Petition to Review the UR. Section 127.208(e), (g)
- Downcoding proposals do not lengthen the time. Section 127.208(d).

Fee Review Process: GRAPP Applies

- The Hearing Notice contains this language:

  - The Workers' Compensation Medical Cost Containment Regulations, 34 Pa. Code § 127.257, et seq., and the General Rules of Administrative Practice and Procedure, 1 Pa. Code §31.1, et seq., control the conduct of hearings. Be prepared to present and/or exchange evidence at the first hearing as directed by the Hearing Officer.

Fee Review Process: The Application

- Provider must submit the Application for Fee Review within 30 days of the disputed treatment (date provider received the denial) or 90 days after the original billing date, whichever is later. Section 127.252
- Deadline is suspended if there is a UR pending.

Fee Review Process: Fee Review Section

- The Application is reviewed by the Medical Fee Review Section.
- The Fee Review Section will return your application as premature if:
  - The Insurer has denied liability for the alleged work injury.
  - The Insurer has filed a UR Request.
  - The 30 days for payment has not passed. Section 127.255.

Fee Review Process: Determination

- The Fee Review Section will issue a determination within 30 days of receipt of all required documentation from the Provider. Section 127.256.
- If the amount was contested, the Fee Review Section will identify the WC allowance for payment and calculate the amount due (or not due) to Provider. The FR Section will also provide a reason for its decision.

Fee Review Process: Hearing Office

- Provider or Insurer have the right to appeal the Fee Review Section's Determination to the Medical Fee Review Hearing Office. Section 127.257.
- Requests for Hearing may be submitted through WCAIS or by mail within 30 days of the Fee Review Section's Determination.
  Section 127.257.

Fee Review Process: Hearing Office

- Request for Hearing is assigned to Hearing Officer and dispute is opened in WCAIS. Section 127.259
- Typically, Insurer has the burden of proof.
- Parties may submit evidence and briefs. Section 127.259
- Hearing Officer will issue a written decision within 90 days of the close of the record. Section 127.260

Fee Review Process: Self-Referral

- The Fee Review Section will not issue a decision if self-referral is raised. It will send the fee review directly to the Hearing Office.
- Section 127.302 states:
  - A provider who has been denied payment of a bill under subsection (a) may file an application for fee review with the Bureau under § 127.251 (relating to medical fee disputes — review by the Bureau) An application for fee review filed under this subsection will be assigned to a hearing officer for a hearing and adjudication in accordance with the procedures set forth in §§ 127.259 and 127.260 (relating to fee review hearing; and fee review adjudications).

Fee Review Process: Commonwealth Court

Parties may file a Petition for Review to the Commonwealth Court within 30 days of receipt of the Hearing Officer's Decision. Section 127.261.

Case Law Update

Due Process – C&Rs

- The Commonwealth Court and Supreme Court have affirmed that Providers may not be denied payment without due process.
  - Armour Pharmacy v. BWCFRHO (Nat'l Fire Ins. Co. of Hartford) (Armour I), 192 A.3d 304 (Pa. Commw. Ct. 2018):
    A C&R may not exclude healthcare providers from payment without proof the provider consented to the arrangement in the C&R.
  - Workers First Pharmacy Services, LLC v. BWCFRHO (Cincinnati Ins. Co.), 216 A.3d 544 (Pa. Commw. Ct. 2019):
    Employer who releases Claimant from responsibility for debts in a C&R remains responsible for the debt and subject to the Fee Review process.

- Practical implications:
  - Existing liabilities to third parties cannot be extinguished via C&R.

Authority of Hearing Officer

- Philadelphia Surgery Center v. Excalibur Insurance Mgmt. Servs., LLC (BWCFRHO), No. 420 C.D. 2022 (Pa. Commw. Ct. Jan. 27, 2023).
  - "Accordingly, while the Fee Review Section and the Hearing Office properly determined the fact and amount of the overpayment, in the absence of legislative authority permitting the Bureau to direct a provider to reimburse an insurer for an overpayment of fees for medical services, neither the Hearing Office nor this Court may create such authority in contravention of the Act."

Utilization Reviews

- Keystone Rx LLC v. BWCFRHO (CompServices Inc.), 265 A.3d 322 (Pa. Dec. 22, 2021).
  - The Pennsylvania Supreme Court affirmed that providers are entitled to due process in fee review proceedings.
  - The Court affirmed that if a UR finds that a treatment is not reasonable or necessary, then the Provider is not entitled to payment.

Utilization Reviews and Causal Relatedness

- The Commonwealth Court has held that an Insurer may not deny payment based on causal relatedness if (1) there is an accepted injury, (2) Insurer had 30 days to submit payment, and (3) there was no Utilization Review.
  - *Workers First Pharmacy Services, LLC v. BWCFRHO, 225 A.3d 613 (Pa. Commw. Ct. 2020).*
  - *Omni Pharmacy Services, LLC v. BWCFRHO (Am. Interstate Ins. Co., 241 A.3d 1273 (Pa. Commw. Ct. 2020), pet. for reargument denied (Pa. Commw. Ct. 2020), pet. for allowance of appeal denied (Pa. June 28, 2021).*

Utilization Reviews and Causal Relatedness

- *UPMC Ben. Mgmt. Servs. v. United Pharmacy Servs. (Bureau of Workers ' Comp. Fee Review Hearing Office),* 287 A.3d 474, 481 (Pa. Commw. Ct. 2022).
  - "Accordingly, we conclude that UPMC was obligated to dispute liability for Claimant's treatment through the utilization review process in order to render Pharmacy's fee review applications premature. UPMC's "defense" that the treatment was not causally related to Claimant's work injury was 'just another way of stating that the compound cream was not a reasonable or necessary 'procedure' for treating Claimant's 'diagnosis[.]'"

- See Also *State Workers' Insurance Fund v. Harburg Medical Sales Co., Inc. (Bureau of Workers' Compensation Fee Review Hearing Office)*, 287 A.3d 981 (Pa. Commw. Ct.2022)

- Practical Implications and Questions:
  - Employers/Insurers need to submit UR Requests before denying payment based on causal relatedness.

Provider Identity

- Hearing Officers may decide whether a putative provider is a provider.

  - *Armour Pharmacy v. BWCFRHO (Wegman's Food Markets, Inc.) (Armour II),* 206 A.3d 660 (Pa. Commw. Ct. 2019).

Provider Identity

Direct Medical Equipment Suppliers

- **Harburg Med. Sales Co. v. PMA Mgmt. Corp., 263 A.3d 71, 2021 Pa. Commw. Unpub. LEXIS 476, 2021 WL 3852290 (Pa. Commw. Ct. 2021).**
  - This is an unpublished decision in which the Commonwealth Court determined that Harburg Medical Sales, a direct medical equipment supplier, was not a provider under Section 109 of the Act and therefore could not use the fee review process.
  - The Court concluded that Harburg is not a licensed health care provider and instead provides equipment and supplies directly to injured workers.

- **Harburg Med. Sales Co. v. PMA Mgmt. Corp., 287 A.3d 981 (Pa. Commw. Ct. 2022).** The issue came before the Court again, but the Court held that SWIF waived the challenge by failing to raise it during the fee review proceedings.

Provider Identity

- Practical Implications:

  - Identity of provider may be litigated before (1) Hearing Officers and (2) WCJs in the course of a claim or penalty proceeding.

Average Wholesale Price

- *Indemnity Insurance Co. of N. America v. BWCFRHO (Insight Pharmacy),* 245 A.3d 1158 (Pa. Commw. Ct. 2021).
  - The Bureau properly used an AWP from a nationally recognized pricing schedule (RedBook) to calculate the amount owed to the pharmacy.

Billing Codes

- *Legion Ins. Co. v. BWCFRHO(Ferrara),* 42 A.3d 1151 (Pa. Commw. 2012).
  - Insurer may not deny payment because Provider's invoice used a temporary, non-Medicare code, i.e. one not found on the PA Workers' Compensation fee schedule. The Court affirmed the FRHO's Order of payment after the Fee Section found for Insurer. There was no corresponding Medicare payment code, and therefore the Provider was entitled to 80% of the usual and customary charge or actual charge, whichever is lower.

Trauma and Burn Cases

- *Geisinger Health System and Geisinger Clinic v. BWCFRHO (SWIF), 138 A.3d 133 (Pa. Commw. Ct. 2016), and Allegheny General Hospital v. BWCFRHO (SWIF), 143 A.3d 449 (Pa. Commw. 2016).*
  - These cases address calculating usual and customary charges to properly reimburse provider in "trauma" cases.
- The issues re: "trauma" exceptions are currently before the Commonwealth Court, listed for Oral Argument 3/6/2023, in *Inservco Ins. Servs. Inc. v. St. Luke's (Soto),* 69 C.D. 2022.

Medical Marijuana

- *Fegley, as Executrix of the Est. of Sheetz v. Firestone Tire & Rubber (Workers' Comp. Appeal Bd.)*, ––– A.3d ––––, 2023 WL 2543474 (Pa. Cmwlth. No. 680 C.D. 2021, 2023).
- *Appel v. GWC Warranty Corp. (Workers' Comp. Appeal Bd.)*, ––– A.3d ––––, ––––, 2023 WL 2543141 (Pa. Cmwlth. No. 824 C.D. 2021, 2023)
  - Employer/Carrier must reimburse out of pocket expense directly to Claimant related to the purchase of medical marijuana that is reasonable, necessary, and causally related to the work injury.
  - Reimbursing Claimant's out of pocket expenses does not cause the Employer/Carrier to violate federal law.
- Where do we go from here?

Thank You

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Questions?