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Medical Provider NEWS UPDATE

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WORKERS' COMPENSATION

SOCIAL SECURITY DISABILITY

IN THIS ISSUE

How to get your bills paid...

The reporting and billing process under the Pennsylvania Workers' Compensation system can frequently be confusing and frustrating for medical providers who treat injured workers. There are some important differences between the typical private insurance plans and workers' compensation insurance. Familiarizing yourself with these differences and communicating with your patient's attorney can make the process less stressful.

One of the most frequently misunderstood aspects of treating the injured worker is the requirement that he or she treat only with the medical providers on the employer's panel for the first 90 days. Both the injured worker and his or her doctor should be aware that this requirement exists only in those cases where the employer has:

There are important differences between private insurance plans and workers' compensation insurance.

1. Posted a panel of doctors ***and***;
2. Obtained a signed acknowledgment from the injured worker of his or her obligation to treat with the panel doctors.

Perhaps the most significant distinction is the lack of a pre-approval or pre-certification process under workers' compensation law. There is no statutory provision or regulation which requires the workers' compensation insurance carrier to authorize treatment or guarantee payment in advance of medical services being rendered. ***Therefore, it is very important that the medical provider, if possible, consult with the injured worker's attorney to determine the precise recognized work injury or diagnosis.*** Ideally, the patient or his attorney will be able to provide the operative legal document that describes the accepted injury.

Once treatment is rendered, the provider ***should bill the workers' compensation carrier by submitting standard CMS-1500 forms*** along with supporting medical documentation, such as office notes,

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2011 Medical Records Fee Schedule

The Pennsylvania Department of Health has announced the 2011 Fee Schedule for Medical Records in the *Pennsylvania Bulletin*.

The Fee Schedule specifies the amounts that may be charged by a health care facility or health care provider upon receipt of a request or subpoena for production of medical charts or records.

	Not to Exceed
For pages 1-20	$1.34*
For pages 21-60	$.99*
For pages 61-end	$.33*
For microfilm copies	$1.97*

*Per Page

Flat fee for production of records to support any claim under Social Security $25.24

Flat fee for supplying records requested by a district attorney $19.92

In addition to the amounts listed above, charges may also be assessed for the actual cost of postage, shipping and delivery of the requested records.

Detailed information can be found at pabulletin.com, Volume 40, Number 49.

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Medical Providers: Case Law That Affects YOU

UR Determinations

In the case, *Shaw v. Workers' Compensation Appeal Board (Melgrath Gasket Co.),* 997 A.2d 404 (Pa. Cmwlth. 2010), the Court reversed the grant of a Petition to Review a Utilization Review (UR) Determination and found that the medical provider failed to provide medical records in a timely fashion to the UR reviewing organization when it sent a CD of the records within 30 days, ***but failed to give a password or instructions about opening the materials.***

Petitions to Review UR Determinations

In the case, *Scranton School Dist. v. Workers' Compensation Appeal Board (Carden)*, 994 A.2d 1162 (Pa. Cmwlth. 2010), the Court held that the filing of a Petition to Review a Utilization Review (UR) Determination, which found the treatment to be reasonable, does not suspend the insurer's obligation to pay the medical bills that were the subject of the UR request under Section 306(f.1)(5), 77 P.S. §531(5), during the pendency of the litigation.

Utilization Review

In the case, *Sexton v. Workers' Compensation Appeal Board (Forest Park Health Center)*, 974 A.2d 546 (Pa. Cmwlth., 2009), the Commonwealth Court determined that a medical provider under review must submit a ***verification of records form*** to the Utilization Review organization. Even if the medical provider sends the claimant's medical records, without the verification form, it will be treated as if no records were sent at all. ***A copy of the verification form can be found in the firm's medical guide "How to Get Your Workers' Compensation Patient Bills Paid." Please contact the firm at 215-587-8400 or info@paworkinjury.com to get your free copy.***

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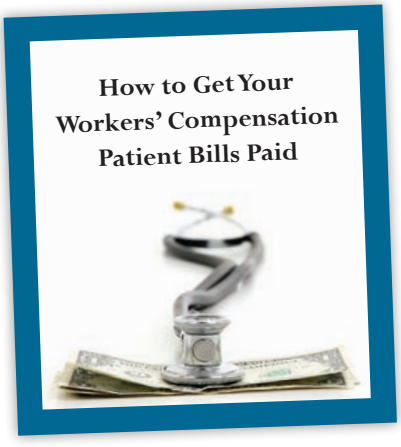
operative reports, diagnostic test reports, etc. The carrier is obligated to make payment within 30 days of receipt of the bill. Payment is made pursuant to a fee schedule. ***Any dispute regarding the amount or timeliness of payment from the carrier is resolved by the provider filing an Application for Fee Review***; thereafter a representative of the Bureau of Workers' Compensation will contact the parties to resolve the issue.

THE UTILIZATION REVIEW PROCESS

Under Pennsylvania Workers' Compensation Law, a carrier can file a Utilization Review Request when it feels that the provider's service is not reasonable or necessary for the treatment of the work injury. The assigned Utilization Review Organization (URO) will make a determination regarding the treatment. Both the provider and the carrier have the option of challenging the URO's determination by requesting a hearing before a Workers' Compensation Judge.

It should be noted that the Utilization Review process does provide the only type of pre-approval process available under Pennsylvania Workers' Compensation. ***A provider can file a prospective Utilization Review Request to ask the URO to make a determination on whether proposed treatment is reasonable and necessary.*** This process, however, takes at least several weeks and, therefore, is only practical for very expensive treatments that are scheduled some time in advance, such as invasive surgery.



If you would like more detailed information including samples of the forms you need to get your bills paid, please contact Jill Mitchell at jmitchell@paworkinjury.com to request a copy of our free guide.

Meet the Team: **Medical Business Development**

Martin Banks employs a team approach to all aspects of our business including our medical referral business. The Medical Business Development Team consists of two people who do different but overlapping jobs.

Jill Mitchell

Jill Mitchell is our Medical Coordinator. In this role, she maintains relationships with the firm's referring doctors in the region to ensure we have a large network of doctors to whom we refer our clients.

Jill has an extensive background as a pharmaceutical sales representative working in a variety of places ranging from Florida to Singapore.

Paul Paoletti

Paul Paoletti is our Client Care Coordinator. In this role, he manages the process of making client referrals to our extended network of doctors. He also maintains a database of the type of practice and geographical location for doctors and makes referrals to clients based on these and other factors.

Paul has been with us for five years. Before joining the Medical Team in June 2010, he was an assistant on an attorney's team. He has extensive knowledge of workers' compensation law and how our firm functions.

We are aware you may have patients who need legal representation for workers' compensation matters, just as we have clients who need medical treatment for their work injuries and disabilities. We look forward to working together to assist the people we mutually represent.

Can you help us expand our network of experienced doctors? If you know a colleague who is looking to work closely with a workers' compensation law firm, please contact Jill Mitchell to arrange a lunch or dinner meeting.

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Join Our Green Effort

In an effort to produce less waste and be a green firm we would like to have your e-mail. If you would like to receive information via e-mail from us periodically, please go to: **www.paworkinjury.com**

Joe Capitan Introduces a Long-Term Disability Practice

Employee benefits such as short-term and long-term disability provided through employer group insurance plans are, most commonly, regulated by the federal government through a complex scheme of laws pursuant to the Employee Retirement Income and Security Act (ERISA). ERISA sets forth strict deadlines regarding all aspects of claims processing that both you and the insurance company must follow. If the claimant fails to file a claim or appeal a denial or termination of benefits in a timely manner, they may lose the right to sue their employer or the insurance company in court. If a claim or appeal has already been filed and there has been no response from the insurance company, one should not allow time to pass without knowing the deadlines that apply in a particular case, especially the deadlines pertaining to the submission of supportive evidence. ERISA is complex and difficult to thoroughly discuss in this article; however, one must be vigilant in protecting one's right to employee benefits.

If you have a patient who is need of assistance with their Long-Term Disability claim, please contact Joseph Capitan at jcapitan@ssdisabilityfirm.com.

Social Security Disability Insurance (SSD or SSDI) *is for people with a steady work history prior to becoming disabled. Monthly benefits are based on how much you paid into the system through Social Security payroll taxes.*

Supplemental Security Income (SSI) *is for people who do not qualify for Social Security Disability because they have never had a job or worked only sporadically over the years. The benefits are a fixed amount. In 2010, the federal benefit amount is $674.00 per month.*

How to determine if a patient is a good candidate for Social Security Disability (SSD) benefits.

1. The patient is out of work (for 12 months or with the expectation of 12 months or more)
2. The conditions (both physical or mental) are such that it is reasonable to believe they will be out of work for 12 months. For example, a broken ankle will heal within 12 months. However, RSD/CRPS of a lower extremity that may cause unimaginable pain could be a good case.
3. The patient has a work history where he/she paid Social Security taxes. (General rule of thumb: If a person has worked and paid taxes five out of the past 10 years, they have Social Security Disability insurance. The best indicator is the Statement of Earnings they receive from SSA about three months before their birthday.)
4. They cannot perform work they did in the past.
5. They cannot perform any work, 8 hours per day, 5 days per week (This includes jobs that are very light and/or sedentary in nature, including 'Walmart Greeter' or 'locker room attendant'). This is by the far the most difficult step in the evaluation process.

Additional Social Security Disability Tips:

- Statistically, it is easier to get SSD benefits if you are over 50 years old.
- On average 75% of first time-applicants for Social Security Disability benefits receive a denial. The next step is an appeal which leads to a hearing before a Judge. Attorney assistance is necessary at the appeal level. However, we can also provide assistance on the application level.
- Even if you're not sure, refer it to us. There is no fee unless we win, and the patient receives a free consultation to discuss his or her rights.

For more information about Social Security Disability rights, please contact our SSD Team at ssdteam@ssdisabilityfirm.com.

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