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# MEMORANDUM

November 8, 2010

To: All Judges and Attorneys

From: Peter J. Calderone, Director and Chief Judge

Subject: Task Force on Medical Provider Claims

Enclosed is the Report of the Task Force on Medical Provider Claims which was chaired by Administrative Supervisory Judge Virginia Dietrich for your review.

We will be considering the Report for possible statutory amendment, agency regulation or policy guidelines. Your comments would be appreciated and can be sent to this office by e-mail to peter.calderone@dol.state.nj.us or by fax to 609-984-2515.

Enclosure

**NJ DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT**
**DIVISION OF WORKER' COMPENSATION**

# TASK FORCE ON MEDICAL PROVIDER CLAIMS

**Submitted November 5, 2010**

**Virginia M. Dietrich**
**Administrative Supervisory Judge**
**Task Force Chair**

**NJ DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT**
**DIVISION OF WORKERS' COMPENSATION**

# TASK FORCE ON MEDICAL PROVIDER CLAIMS
## List of Members

**Virginia M. Dietrich, Administrative Supervisory Judge, Task Force Chair**

**Michelle Haas, Esq., Hoagland, Longo, Moran, Dunst & Doukas**

**Mark S. Jacobs, Esq., Jacobs, Schwalbe and Petruzelli**

**Mark Setaro, Esq., Weber, Gallagher, Simpson, Stapleton, Fires & Newby**

**William Barrett, Esq., New Jersey Manufacturers Insurance Company**

**Steven Cohen, Esq., Davis, Saperstein & Salomon**

**James Aragona, M.D. – Garden State Orthopaedic Surgery**

# TASK FORCE REPORT ON MEDICAL PROVIDER CLAIMS

Insurance carriers and medical providers have experienced an increase in disputes concerning the appropriate payment for medical treatment rendered to petitioners. Consequently, medical providers have sought to have these disputes addressed in a variety of forums. The Division of workers' Compensation has experienced a significant increase in the filing of these disputed claims. This has resulted in a delay in the administration of petitioner's claims before the division. Due to the volume of these claims, all interested parties are seeking a means by which to address these disputes as efficiently, quickly and fairly as possible.

At present, the law permits medical providers to file their own application in the workers' compensation court to bring the issue to the fore, or in the alternative, to file a motion to intervene in a case already filed by a petitioner. See, N.J.A.C. 12:235-3.10(a) (3). Medical provider applications (hereinafter, "MPCs") may be filed with the Division of Workers' Compensation (hereinafter, "the Division"), whether or not the petitioner has already filed a claim petition. Motions to intervene, by their very nature, require that an underlying claim petition already exist. The Division has created the appropriate forms to support an MPC by a medical provider. The sheer number of MPCs that have been filed in the Division spurred the creation of this Task Force. We have been asked to review the proper procedures to handle these MPCs and to make appropriate recommendations, including, but not necessarily limited to: addressing the burden of proof that our legal system imposes upon the parties; to bring uniformity within the Division of Workers' Compensation in the administration and adjudication of these disputes and to ensure that the benefits of the injured worker are protected.

**THE ISSUES**

At the first meeting of our Task Force, several issues were addressed; they will be touched upon here in no particular order of importance. Pursuant to statute N.J.S.A. 34:15-15, the employer is empowered to authorize all medical providers in an accepted compensable workers' compensation claim. With that right, employers, through their workers' compensation insurance carrier or administrator, often enter into contracts with certain medical providers to provide services. This, however, is not the norm. In most cases, it would appear that there are no written contracts between the insurance carriers and medical providers. There is often no written understanding between medical providers and insurance carriers as to what constitutes reasonable and customary charges. The parties in these disputes rely on the medical provider codes, often referred to as CPT (Current Procedural Terminology) or HCPCS (Healthcare Common Procedure Coding) that are assigned to particular units of medical treatment to determine the appropriate charges. It quickly became apparent to this task force that such coding is both an art and science. Assigning the appropriate codes can be a labyrinthine process that falls within the expertise of individuals trained in the coding process. Medical bills are generated by utilizing these codes, and insurance carriers and administrators pay for medical benefits based upon coded procedures. There are independent companies who have been used by insurance carriers to review coded bills, revise bills and to negotiate the disputes that invariably arise between the medical providers and the insurance companies. Some carriers effect this process in-house.

In medical provider claims, the issue typically is not a contractual one; instead, the issue often is what constitutes the usual, customary and reasonable charges and the payment that should be made for a given medical service rendered to an injured claimant.

One primary concern for this Task Force was the manner in which a MPC should be handled in conjunction with the underlying claim petition. For example, can the petitioner's claim petition be resolved without the resolution of the medical provider claim? The Task Force also considered the burden of proof needed to establish the medical provider's case. See, N.J.S.A. 34:15-15.1. Discovery issues and representation by counsel were also addressed by the Task Force.

**FINDINGS & RECOMMENDATIONS**

The Task Force was charged with a review of the current situation involving medical fee disputes. The Task Force was comprised of a judge, five attorneys and a surgeon. The attorneys on the Task Force represent both petitioners and respondents. As part of our charge, the Task Force requested information from several groups that actively participate in the handling of MPCs. We heard presentations on behalf of hospitals, trauma centers, physicians, insurance carriers and companies that examined medical bills and attempt to resolve disputes between medical providers and carriers.

The Task Force also requested statistical information from the Division. The Division does keep track of filed MPCs; however, it does not track numbers for motions to intervene. At our request, Mr. Christopher Leavey, Administrator of the Division, generated statistics to aid in

our analysis. In 2009, the Division received 1210 MPCs. The filings to date for the year 2010, extrapolated out over the course of a full year, would yield approximately 1400 MPCs for this year.

During our meetings, it came to the attention of the Task Force that "balance billing" is a problem. This is the practice wherein authorized medical providers accept fees paid by the carrier and then issue a bill to the petitioner for any remaining balance. In an effort to eradicate this practice, the Task Force recommends an amendment to N.J.S.A. 34:15-15. Section 15 of the Act requires that employers furnish and pay for physicians, surgeons and hospital services for the injured worker. Having reviewed the statute and the case law, the Task Force believes that there is a need to clarify that balance billing in the workers' compensation setting is inappropriate. Accordingly, the Task Force recommends the following amendment to N.J.S.A. 34:15-15 which we would propose would appear as a paragraph between the final two paragraphs of that section. This additional language would read as follows:

> "Fees for treatments that have been authorized by the employer or its carrier or its third party administrator, or which have been determined by the court to be the responsibility of the employer, its carrier or third party administrator, shall not be charged against or collectible from the injured worker. Sole jurisdiction for any disputed medical charge arising from a workers' compensation claim shall be vested in the Division of Workers' Compensation."

In regard to the negotiation of workers' compensation claims at the pretrial level, it is the Task Force's recommendation that where a claim petition for permanency and an MPC claim have been filed, the Division should consolidate and list the claims together. The Division should use all possible resources to identify and link related claims. Although the claims would

be consolidated and listed together, and while the Task Force recognizes that it is judicially efficient to dispose of all claims in one proceeding, it is our opinion that a settlement of an injured workers' claim petition should not be delayed until such time as the MPC claim has been resolved. Conversely, if the carrier and the medical provider have settled their claim, there should be no barrier to entering an Order disposing of the MPC matter in advance of the petitioner's settlement/trial. In other words, when a related claim petition and MPC claim exist, they can be resolved separately. With Motions to Intervene, it is difficult to resolve petitioner's underlying claim petition without resolution of the disputed charges. Therefore, it is the opinion of the task force that the filing of an MPC is preferable to the filing of a Motion to Intervene.

The Task Force is of the opinion that continuing education is crucial to efficient and effective handling of medical provider application claims. We would encourage an educational campaign directed to the bench, bar and carriers to familiarize them with the proof requirements and procedures. It is suggested that time be allotted at the next Bench Bar meeting to review the findings of this Task Force.

During the various presentations before the Task Force, it became evident that many medical providers were seeking a streamlined procedure, something akin to arbitration or an "informal" in order to quickly resolve their disputes with the carrier. The Task Force recognizes that the law of New Jersey and our statute in particular, does not permit an informal handling of such claims. The law in New Jersey requires that a corporation be represented by an attorney at law in any judicial proceeding. This means that the medical providers, doctors and hospitals who wish to pursue a cause of action in the Division must retain counsel. Often, the attorney

representing the entity responsible for paying the medical benefits may differ from the respondent counsel in the underlying claim. If the case must be tried there may also be a need for the production of expert witnesses to establish what constitutes usual customary and reasonable charges and payment.

Recently, there was a proposal for rules which would permit an informal disposition of medical provider claims; however, rules were never promulgated to effectuate this suggestion. Moreover, the majority of comments provided to this committee concerning an informal procedure were overwhelmingly negative.

Certainly, the medical providers and carriers do not have to use the workers' compensation court as a venue to address their disputes. If they so choose, these parties can agree upon an arbitration or mediation process. Presently, they can also litigate the matter in the Superior Court, as well. However, if they choose to litigate the dispute in the Division, it is the opinion of the Task Force that the parties must submit to the Rules of the Division. Once a party submits an MPC claim, it is the Task Force's opinion that the party bringing the claim has the burden of going forward with proofs for every element in contention. Each claim is unique and stands or falls on its own merit. Discovery may be necessary and special interrogatories should be permitted as provided for by the Rules of the Division.

The parties to a MPC claim in the Division should be required to adhere to the Rules of the Division concerning discovery. A medical provider should be required to produce the corresponding medical records to substantiate its claim. Either party, however, can file a motion

for a protective Order with the court should a discovery request be overreaching or should a given discovery request seek proprietary information or processes. In presenting proofs before the court, and in response to discovery, judges should insure that names and personal identifying information included in the records, other than that of the Petitioner, be redacted before being presented to all parties. Discovery, in the discretion of the Court, should be broad, to determine the full range of payments in the geographical area for the medical procedure or service at issue. Selected samples of payments made for similar services will not suffice.

The medical provider may be required to testify in order to substantiate his or her claim. However, if the dispute only concerns the amount of the payment, and not the necessity of the treatment, the parties may be able to litigate the matter without the testimony of the actual medical provider. Many times, in this setting, we can envision a scenario where the only issue is one of assessing the appropriateness of the medical coding. The accuracy of the coding could be determined by a judge from the testimony of each side's respective coding expert.

There are many factors that a judge may consider in determining the usual, customary and reasonable (UCR) charges of a given medical treatment and the appropriate payment for said treatment. While the list below should not be considered to be exhaustive, it certainly can act as a useful guide for the parties to consider in presenting proofs and likewise, to the jurist, in deciding a case:

1. The new WCRI report, Benchmarks for Designing Workers' Compensation Medical Fee Schedules. Fee schedules vary dramatically from state to state and based upon the type of payer;

2. The fees customarily paid for like services within the same community;

3. The fees paid to the same physician or medical provider by other payers for like treatment;

4. The fees billed and the accepted payments for such bills by a given provider. The Court may wish to consider the disparity in payments accepted from different sources (i.e. Medicare vs. PIP and commercial carriers);

5. A review of the Health Insurance Claim Forms ("HCFA") submitted by the provider to the claim payer and the Explanations of Benefits ("EOB") that that claim payer sends to the provider. The EOB provides the amount billed for a given procedure or service performed on a particular date of services. The EOB also provides the amount paid and, where applicable, identifies the reason why a disparity may exist in the amount billed and the amount paid. The use of certified professional coders may be employed to review the bill along with the medical records to be sure that it is consistent with CPT coding standards;

6. The HCFAs or EOBs from other medical providers in the same geographic area or community for the same medical treatment provided;

7. Using commercial and/or private databases such as Ingenix's Prevailing Healthcare Charges System ("PHCS"); the Medical Data Resource ("MDR") database, and; Wasserman's Physician Fee Reference ("PFR") database to name a few;

8. The type of facility where the procedure was performed. For example, was the services provided at a Level 1 trauma center versus a community hospital;

9. Consideration of whether there was a contract between a claim payer and the medical provider, such as a PPO network, in which case the contract would be controlling;

10. Consideration of Medicare/Medicaid reimbursement rates;

11. Testimony from medical office personnel as to what services were billed for, the payments received and how the bill was formulated;

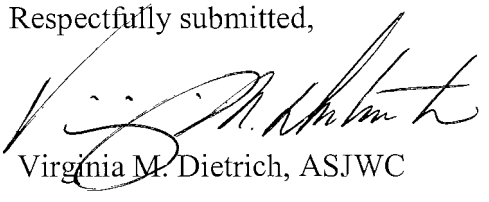
12. Consideration of state sanctioned PIP fee schedules;

13. Consideration of commercial carrier authorized payments.

**Conclusion**:

The opinions expressed in this document reflect a consensus among the Task Force members. This Task Force has attempted to identify and address the difficulties that have arisen as a result of the influx of the MPC petitions. Certainly there are no overnight solutions. We made the foregoing suggestions to assist our courts and our practitioners in resolving these claims. As the parties become more familiar with the new terms and concepts, the process for handling these claims will become smoother. Every opportunity should be taken to discuss issues that arise in the handling of medical provider claims. With education and experience the parties will learn the techniques necessary to quickly resolve the disputes. The Division can expect that what now appears as thorny problems will eventually become part of the regular day-to-day negotiations in our courts.

Respectfully submitted,



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