Is your Pennsylvania Trauma Facility being short-changed by Workers' Compensation Insurers?

Sean Audley, Esquire
Audley Law Offices, P.C.

If you are a Pennsylvania Certified Trauma facility, you are invariably familiar with the significant difference in reimbursement for non-trauma workers' compensation cases versus trauma cases. The Pennsylvania State Workers' Compensation fee schedule carves out an exemption for treatment provided to seriously injured workers at hospitals with certified level I or II Trauma Centers or American Burn Association certified Burn Units. The workers' compensation exemption states that in such matters hospitals are to be paid its "usual and customary charge". For more than 22 years, this meant that the hospital was paid its full billed charges. That may be changing and it is important for trauma and burn unit hospitals to be prepared to react to the changing rules regarding such payments.

In 2015, one of Pennsylvania's largest providers of workers' compensation coverage began to pay trauma claims at less than the provider's billed charges. Using a Bureau of Workers' Compensation (BWC) "Statement of Policy" on a wholly unrelated matter, they determined that trauma and burn claims should only be paid in accordance with a usual and customary fee schedule put out by Fair Health, a New York based non-profit that studies medical payments. *Where applied, this database has resulted in payments on trauma and burn claims being reduced by 25 to 33 %.*

Several cases challenging this made it to the Commonwealth Court in 2016. In the initial decisions, involving challenges brought by Geisinger Medical Center, the Court questioned the use of the Fair Health Database but affirmed the reduced payment.

> *Your facility should continue to expect no less 100% of billed charges [for trauma and burn cases].*

Most recently, however, in a case handled by Audley Law Offices we challenged the application of the Fair Health Database. Within case Allegheny General Hospital v. The Bureau of Workers Compensation, 143 A.2d 449 (2016) the Court held that a proper challenge had been raised to the use of the database to reduce a payment by nearly a third and stated that it was improper for the Hearing Officer to have relied on it. The decision upholding the reduced payment was reversed and the matter remanded to the Fee Review Hearing Officer.

The Court did not, however, hold that providers were to continue to be paid their billed charges. The court held that payment on such claims had to be the "'charge most often made by providers of similar training, experience and licensure for a specific treatment, accommodation, product or service in the geographic area where the treatment, accommodation, product or service is provided." Because the Fair Health Database was not limited to trauma or burn units in the geographic area of Audley Law Offices' client, using it was an error. **Based upon this case, your facility should continue to expect no less 100% of billed charges.**

AUDLEY LAW
Audley Law Offices, P.C
audleylawoffices.com | 800.758.9720

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HOW DOES THE CASE IMPACT YOUR FACILITY

As a result of Allegheny General Hospital v. The Bureau of Workers Compensation, 143 A.2d 449, whether you have noticed a reduction in payment to your facility or not, you should ask yourself the following questions:

1. Is my facility filing timely Applications for Fee Review on underpaid trauma and burn unit claims?

Once you receive an explanation of benefits reporting and payment other than the full billed charges, or if 60 days have passed since the claim was submitted and no payment has been made, your facility should immediately file an Application for Fee Review. The Medical Fee Review Division of the Bureau has not been using any database to reduce payments and are likely to direct full payment of claims that meet the trauma or burn criteria.

2. Does my facility flag trauma and burn cases so that Applications for Fee Review can be filed properly and timely?

Your follow up staff should be aware of the time limits for filing Applications for Fee Review, which are 30 days from the date of the EOB or 90 days from the date the claim is originally submitted. Too often, the timely filing limit passes while a provider rep is working with a claims adjuster to address the late or insufficient payment. The law does not excuse a late filing for that reason and the Application will be denied as untimely.

You should also make sure that there is little to no delay in getting the EOB to the appropriate provider rep to assure timely filing.

3. Are you challenging adverse fee review decisions by requesting a hearing?

If a provider receives an adverse determination by the Medical Fee Review Office, a Request for De Novo Hearing should be immediately be filed, preferably through legal counsel experienced in handling such matters. The insurance company has the burden of proving that their payment was proper under the law. There is currently no database that provides what charges are usual and customary for trauma or burn units by geographic region in Pennsylvania so a carrier is unlikely to prevail at any hearing. Failing to timely file a proper Request for De Novo Hearing can be fatal to any review. Not properly following the procedure or objecting to the carrier's failure to do so can also result in unfavorable decisions on issues other than the merits of your case. Many trauma and burn claims involve hundreds of thousands of dollars in charges and avoidable errors can result in the loss of those funds.

YOUR FREE LEGAL ADVICE

It is in your best interest to review every trauma and burn unit bill in a work-related case as soon as possible and to challenge any payment of less than the billed charges through the fee review process. Failing to so will result in your forfeiture of any right to secure the proper payment, leaving your facility "short changed".

Audley Law Office, P.C. is a boutique law firm dedicated to assisting hospital facilities in receiving the optimal reimbursement legally available to them. For more information about our law firm, please visit our website at: audleylawoffices.com or feel free to contact me at sean@audleylawoffices.com or (412) 532-0089.