

# Act 203, Section 33

## Workers' Compensation Workgroup Report

January 15, 2009

TO

Senator Douglas Racine, Chair, Committee on Health and  
Welfare

Senator Vincent Illuzzi, Chair, Committee on Economic  
Development, Housing and General Affairs

Rep. Steven Maier, Chair, Committee on Health Care

Rep. Warren Kitzmiller, Chair, Committee on Commerce



## **Act 203, Section 33, Workers' Compensation Report**

### **Legislative charge**

Section 33 of Act 203 of the 2007/2008 legislative session required the Vermont medical society, in collaboration with the Vermont Association of Hospitals and Health Systems; the Department of Banking, Insurance, Securities, and Health Care Administration; the Department of Labor; workers' compensation carriers; practice managers; and other interested parties, to work to address the following issues and report to the Senate Committees on Health and Welfare and on Economic Development, Housing and General Affairs and the House Committees on Health Care and on Commerce on or before January 15, 2009:

- (1) Timely payment of workers' compensation claims;
- (2) Notification and resolution process for contested claims;
- (3) Enforcement of timely payment, including assessment of interest and penalties;
- (4) Charges for examinations, reviews, and investigations in connection with workers' compensation claims;
- (5) Filing of carriers' written claims processing practices with the Department of Labor;
- (6) Development of online claim processing and claim tracking systems accessible to health care providers; and
- (7) Uniform claims processing standards for workers' compensation insurers.

### **Problem Statement**

Workers compensation insurance in Vermont and nationally represents perhaps the first instance of universal health insurance coverage in this country. Enacted in the early 1900s, it mandates that employers provide both healthcare services and disability payments to workers injured in the workplace. Since it reimburses for healthcare services and disability payments for work-related injuries, workers compensation provides both similarities and differences for health care providers from traditional health insurance coverage.

One major difference for health care providers in dealing with health insurance companies, as opposed to workers compensation insurance carriers, is simply the large number of workers compensation carriers. With only three major health insurance companies in Vermont (BCBSVT, MVP and (CIGNA), compared to approximately 300 companies licensed in the state and 25 companies actively underwriting workers'

compensation policies, providers face a greater deal of variation in claims processing practices, based on the larger number of workers compensation carriers.

A frequently cited problem for both hospitals and health care practitioners, is the time and effort involved in obtaining reimbursement from workers' compensation carriers for healthcare services provided. One study indicated that the total orthopaedic practice expense per episode of care was \$178 for a patient with health insurance and \$299 for a patient with the same condition covered by workers' compensation.<sup>1</sup> And while payment for health care services through health insurance companies will typically be received within 30 days of submitting a bill, payments for the same services provided to a workers' compensation claimant may not be received for a much longer period of time. Although the reasons for delayed payment are varied they typically relate to determining that the healthcare services provided relate to a work-related injury.

The issue of timely payment of workers' compensation claims was the subject of a joint Vermont House and Senate Committee hearing held on April 8, 2008 at the State House. During that hearing, witnesses representing physicians, hospitals, insurance carriers, the Workers Compensation Simplifications Subcommittee of the Common Claims Work Group, and the Department of Labor (VTDOL) and the Department of Banking, Insurance, Securities, Health Care Administration (BISHCA), discussed the issues related to the timely payment of workers' compensation claims.

During the course of this hearing, several major issues emerged. First, although there is existing law in Title 18 related to the timely payment of workers compensation claims, the Vermont Department of Labor's primary statutory authority is found in Title 21 and the Department is unaccustomed to applying provisions found within Title 18. In addition, the Title 18 forty-five day timely payment provision is in conflict with the Department of Labor's Rule 40 thirty-day timely payment provisions. Rule 40 contains the workers' compensation medical fee schedule and it controls most reimbursement issues related to workers' compensation claims.

Second, the Department of Labor indicated that under current law only a claimant could bring a complaint regarding a timely payment problem to the Department of Labor. The department indicated that, in the event of a timely payment issue, a healthcare provider would have the ability to file a lien against payments received by the injured worker. However, under current law the healthcare provider would not have the standing necessary to file a complaint with the Department of Labor.

Finally, the jurisdictional responsibilities relating to the regulation of workers' compensation insurance carriers is currently split between the VTDOL and BISHCA. VTDOL is primarily responsible for ensuring that the claimant's work-related injury healthcare services and disability benefits are received. BISHCA insurance division has primary responsibility for the regulation of all insurance carriers, and its health care administration addresses issues related to health insurance. As with any program where

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<sup>1</sup> Brinker, M.R., O'Connell, D. P., The effect of payer type on orthopaedic practice expenses, The Journal of Bone and Joint Surgery, Inc., 2002: 1816-1822

there is divided responsibility, there is a potential for a lack of sharing of information and coordination of activities.

In order to address these issues, the workgroup developed proposed legislation that includes new standards for the timely payment of workers' compensation medical bills within Title 21 (see Appendix A).

## **Section-by-Section Summary of Act 203 Workers Compensate Work Group Draft Legislation**

### **Section 1**

Section 1 adds new definitions to Section 601 of Title 21. Included are new definitions of "medical bill," "denied medical payment" and the BISHCA Rule 10 definition of "medically necessary care." Also included in the section is a revision to the existing definition of a "healthcare provider" that deletes the current restriction that a healthcare provider has to be authorized to provide health care in Vermont. This last change recognizes the fact that many Vermonters receive their healthcare services at Dartmouth Hitchcock in New Hampshire.

### **Section 2**

Section 2 of the proposed legislation creates a new timely payment provision for workers' compensation claims within Title 21. The provisions of subsection 604(f) would require that within 30 days from receipt of a medical bill for health services from a healthcare provider or an employee, the employer or insurance carrier would pay the bill or notify the injured employee and healthcare provider that the medical bill is being contested or denied.

Paragraph 3 of the subsection makes it clear that disputes regarding medical bills or interest may be filed by the injured employee or the health care provider with the Commission of Labor for resolution. The Commissioner may resolve the dispute or at the option of either party the dispute may be settled by arbitration in accordance with the rules of the American Arbitration Association.

If a medical bill was denied because the employer or insurance carrier was not provided with sufficient information, the employer or insurance carrier has 30 days after receipt of the request additional information to pay the bill. If the insurance carrier fails to pay the medical bill within 30 days following receipt of the request information, interest shall accrue on an unpaid medical bill at a rate of 12%.

If the Commissioner finds the insurance carrier has engaged in a pattern of practice in violating this new subsection, the Commissioner may impose additional administrative penalties against the carrier. In addition, the Commissioner may refer the insurance carrier to the Commissioner of BISHCA for additional sanctions under the provisions of Title 8.

Paragraph 9 of the subsection states that any interest or penalty paid by the insurance carrier would be excluded from the claims data reported to BISHCA and, therefore, would not be included in the employer's future workers' compensation insurance premium.

The health care provider shall submit a medical bill for services provided to the injured employee with supporting medical documentation within six months from the date the healthcare provider has actual knowledge that the services related to a workers compensation claim.

Subsection 604(g) describes what constitutes appropriate medical documentation. Documentation shall describe the injury and it should be sufficiently detailed to allow for the review of the medical necessity for services and the appropriateness of the fee charged. These medical documentation standards are consistent with those contained in the IAIABC Model Act (see Appendix B) as well as those provided under Department of Labor Rule 40.

### **Section 3**

Section 3 of the proposed legislation creates a new subsection in Section 682 of Title 21 relating to the subrogation of claims between workers' compensation carriers and health insurance companies.

It is not uncommon that, after a medical bill has already been filed by a health care provider with a workers compensation carrier, the carrier determines the claim is not due to a work-related injury. Section 3 of the proposed legislation makes it clear that in the event another insurance carrier is responsible for paying the claim, the workers' compensation carrier and the health insurance company will negotiate with each other rather than forcing a healthcare provider to resubmit the claim with supporting documentation to the health insurance company

### **Section 4**

Section 4 of the legislation amends Section 9418 of Title 18 by deleting application of this section to the timely payment for workers' compensation policies. This requirement is no longer necessary with the addition of the timely payment provisions in Title 21. Section 9418 has also been amended by deleting the exclusion of workers' compensation carriers from the recoupment policy enacted in Act 203. The amendments in this section are particularly important, since legislation enacted during the past session inadvertently repealed the workers' compensation timely payment provisions in Title 18.

### **Section 5**

Section 5 of the bill deletes the exclusion of workers' compensation carriers from the Section 28 provisions of Act 203 that relate to claims processing, down coding and adherence to coding rules.

## **Section 6**

Section 6 of the legislation deletes the exclusion of workers' compensation carriers from the Section 29 provisions of Act 203 relating to prior authorization.

## **Workgroup Process**

Consistent with requirements of Section 33 in Act 203, the Vermont Medical Society (VMS) convened the workers' compensation work group by inviting representatives of health care professionals, healthcare facilities, workers compensation carriers, practice managers and state government to participate in the study. A list of the participants who received study group notices documents and other materials by e-mail is attached as Appendix C.

The first meeting of the work group was held on June 20, 2008, and was attended by 16 individuals. At this meeting, the group reviewed its legislative charge and identified a number of substantive issues for further discussion and research.

The issues identified during this first meeting include the discrepancies between the 45-day workers' compensation timely payment provisions found in 18 VSA § 9418 and the 30-day timely payment requirement under Vermont Department of Labor Rule 40.021. There was also discussion on the need for the following issues to be addressed: greater coordination between the VTDOL and BISHCA in the enforcement of workers' compensation laws and regulations; the inclusion of healthcare provider in the definition of claimant for filing a complaint with VTDOL regarding timely payment; updating the maximum allowable amount amounts for anesthesia payments; the applicability of sections 27, 28 and 29 of Act 203 to casualty insurance carriers; and, the development of policy guidelines for claim documentation by health care professionals.

Another issue that was discussed had to do with the Vermont Department of Labor's staffing levels and whether they were adequate to enforce complaints brought by health care providers. A proposed solution to this problem would be the granting the Department of Labor bill-back authority similar to that held by BISHCA for the regulation of the practices of insurance carriers. The authority allows a department to charge a regulated entity for the reasonable cost of regulation.

As a result of these discussions, the group agreed to pursue the following next steps for consideration at the workgroup's next meeting on September 5th:

1. **Rule 40.000 revisions.** Stephen Monahan of the VTDOL was asked to present recommendations on revising Rule 40.000 to address the following: standards of claim documentation by health care professionals; reconciling the 40.021(C)

standard of 30-day timely payments with the 18 VSA § 9418 standard of 45-day timely payment; and updating the maximum allowable amounts for anesthesia payment (last updated in 1995).

2. **Revised definition of Claimant.** Representatives of BISHCA and the VTDOL were asked to jointly develop a revised definition of claimant for the purposes of timely payment and enforcement that includes the injured worker, the employer, the insurance company and the health care professional. Consideration will be given to the placement of this definition in 21 VSA.
3. **Enforcement.** BISHCA and VTDOL were asked to develop recommendations and policies to ensure better coordination and tracking of complaints between the two departments in enforcing workers' compensation laws and regulations relating to health care professionals interactions with insurance companies.
4. **Sections 27, 28 and 29 of Act 203 (H.887).** Workers' compensation policies of a casualty insurer were exempted from the provisions of Sections 27 (PAYMENT FOR HEALTH CARE SERVICES), 28 (PROCESSING CLAIMS, DOWNCODING, AND ADHERENCE TO CODING RULES) and 29 (PRIOR AUTHORIZATION) of Act 203 (H.887). At the next meeting, representatives of these casualty insurer carriers were asked to report back to the committee regarding the appropriateness of their being subject to these three provisions.
5. **VTDOL bill back authority.** In the common claims work group report, it indicates that VTDOL "was not staffed to carry out the law as the subcommittee interpreted it." This is not the case for BISHCA, since it has the ability to recoup payments from insurance companies and other regulated entities for the cost of examinations and enforcement activities. The VTDOL was asked to report on the desirability of being granted similar bill back authority in order to enhance its enforcement capacity.

At the work group's second meeting on September 5<sup>th</sup>, Stephen Monahan of the VTDOL and BISHCA Deputy Commissioner of Insurance Michael Bertrand presented their recommendations regarding a revised definition of claimant for the purposes of timely payment and enforcement, information sharing between BISHCA and VTDOL and a model act for electronic medical billing. They indicated that they had met in July to discuss these issues and they were in agreement that: BISHCA and VTDOL would work to ensure that both departments were aware of billing complaints, so that action could be taken where a pattern or practice of nonpayment or improper payment could be identified and pursued.

In addition, both departments agree that references to workers' compensation medical billing should be deleted in Title 18 and addressed in the workers compensation statute found in Title 21. BISHCA and VTDOL also agree that a uniform definition of "claimant" should be provided in the statutes, and that it should mean service recipient. Where the existing statute references claimant, healthcare provider should be added.

(The effect of this would be that the service recipient, the health care provider and the commissioner would all receive notice when a bill is disputed or more information is requested.)

Prior to the September 5th meeting, Stephen Monahan provided a Model Act on Electronic Medical Billing for Workers' Compensation prepared by the IAIABC that was e-mailed to the workgroup. According to its website, the IAIABC is an association of government agencies that administer and regulate their jurisdiction's workers' compensation acts. Along with these government entities, various private organizations involved in the delivery of workers' compensation coverage and benefits participate in the IAIABC (see <http://www.iaabc.org>). The model act includes proposed sections for medical documentation, standards for timely payment and interest, as well as communication between health care providers and patients (see Appendix B).

A drafting workgroup was formed to develop the legislation proposed by BISHCA and VTDOL consisting of Paul Harrington, Stephen Monahan, Michael Bertrand, Claire Buckley, John Hollar and Mike Deltrecco. The drafting workgroup indicated they would utilize language in the IAIABC model act when appropriate.

Stephen Monahan also updated the workgroup on the VTDOL's position on revising Rule 40.000 in order to reconcile the rule's 40.021(C) standard of 30-day timely payments with the 18 VSA § 9418 standard of 45-day timely payment; and updating the maximum allowable amounts for anesthesia payment (last updated in 1995). He indicated the VTDOL was committed to revising Rule 40.000 to address these issues and others, such as the fee for depositions, but that it was unclear when the VTDOL would file its revisions to the rule.

Neil Haas, M.D., presented the findings of his report entitled: Insurance Reimbursement for Workers' Compensation and Other Outpatient Services at North Country Hospital (see Appendix D). In response to atypically-long delays in payment for services by workers' compensation insurance carriers, Dr. Haas presented data from the Outpatient Billing Office of North Country Hospital (NCH) from seven practices at NCH for a 22-month period.

In his draft summary and conclusions on Page 4 of the report, he found that "When considering the average residence times in accounts receivable at NCH by insurance type, workers' compensation carrier (41 days average in accounts receivable) do not compare favorably to the weighted average for time in accounts receivable for all insurance, which is 26 days. However, the lower hospital aggregate reimbursement time may be influenced by the quickness in payment of insurance carriers with larger volumes (for example, Blue Cross/Blue Shield), well-known and well-defined billing and documentation criteria (Blue Cross/Blue Shield, Medicare, Medicaid), well-defined relationships and agreements with NCH (for example, preferred provider organizations), or less contention about need and payment for services (for example, obstetrics services)."

Again on Page 4 of the draft report, Dr. Haas also made the following suggestions: “In order to understand if and why workers’ compensation insurance carriers are delaying payment, we must make unconfounded comparisons between provision of similar services. We must set standards for documentation so that we can determine when a claim is legitimately delayed due to documentation deficiencies. Guidelines for what determines a legitimate claim and legitimate treatment for an accepted diagnosis would be helpful.”

The workgroup expressed its appreciation to Dr. Haas for the high quality and thoroughness of his research project. He stated that he would present a revised report at a future meeting of the workgroup. Mike Deltrecco (VAHHS) and Claire Buckley (RRMC) indicated they would undertake similar research regarding delays in payment for services by workers’ compensation insurance carriers and report their findings.

During its meeting on October 3<sup>rd</sup>, the workgroup reviewed the October 2nd draft legislation developed by the drafting workgroup. Harrington indicated that the draft bill language reflected VTDOL’s and BISHCA’s recommendation that references to workers’ compensation medical billing be deleted in Title 18 and addressed in the workers’ compensation statute found in Title 21. He pointed out there are three sections in the draft that closely track the provisions of 18 V.S.A. § 9418 and provisions from the IAIABC model act provided by Steve Monahan.

The first section of the draft adds definitions of “medical or health care bill” and “denied medical payment” to 21 V.S.A. § 601. The second section inserts the revised 18 V.S.A. § 9418 requirements into a new subsection 21 V.S.A. § 640(f). Throughout, the 21 V.S.A. terms “employer or insurance carrier” and “injured employee” are substituted for the 18 V.S.A. terms “health plan” and “patient” respectively. Since there is currently a lack of consensus of the time period for paying bills, the draft includes both the Rule 40.000/Model Act’s 30-day standard and the 18 V.S.A. § 9418 45 day standard for timely payment. Harrington also pointed out that under new (f)(3) “Disputes regarding any medical bills under this subsection may be filed with the commissioner by the injured employee or health care provider...”

The draft’s second section also includes a new subsection 21 V.S.A. § 640(g) intended to reflect more detailed document standards. The provision is based on language from the Model Act and Rule 40.000. The third section of the draft deletes the 18 V.S.A. § 9418(c) reference to workers’ compensation insurance policies.

The workgroup reviewed each page of the draft and made a number of suggestions that will be reflected in future drafts. Monahan agreed to draft specific penalties that the Commissioner of DOL may assess for inclusion in paragraph 640(f)(5) of the draft; Stephen Monahan and Michael Bertrand agreed to draft a new paragraph 640(f)(7) on the role of BISHCA; Neal Haas, MD, agreed to provide revised language for subsection 640(g) relating to medical documentation; and John Hollar would submit for review a new subsection 640(h) on the denial of future medical bills relating to the same injury. A

new draft of the proposed legislation was distributed for review prior to the November 14<sup>th</sup> meeting.

John Hollar had been asked to report to the workgroup on the appropriateness of casualty insurers being exempt from the provisions of Sections 27 (PAYMENT FOR HEALTH CARE SERVICES), 28 (PROCESSING CLAIMS, DOWNCODING, AND ADHERENCE TO CODING RULES) and 29 (PRIOR AUTHORIZATION) of Act 203 (H.887). On his behalf, Doreen McLaughlin of Travelers (Travelers Group underwrites approximately 6.4% of the worker's compensation market in the state) spoke against applying Section 28 to casualty insurers, due to her company's desire to be able to continue down-coding medical bills (pay for a lower reimbursed procedure rather than one the billed by the health care provider for treating the injured employee). John Hollar had no clients who wished to speak against applying sections 27 and 29 to casualty insurers.

Mike Deltrecco (VAHHS) presented a list of common workers' compensation issues from hospital billing departments. Many of the issues were identified in the common claims workgroup and documented in their report.

Neil Haas, M.D., provided the workgroup with an updated version of his research paper on Insurance Reimbursement for Workers' Compensation and Other Outpatient Services at North County Hospital. He also discussed the findings from his presentation on The Workers' Compensation Claims/Claims of Workplace Injury and Illnesses and Other Factors, and the experiences and recommendations of Gregory Gilbert, Senior Vice President with Concentra (a company offering employment related healthcare through 321 health care centers in 40 states) (see Appendix D). The workgroup again expressed its appreciation to Dr. Haas for the high quality and thoroughness of his research.

At its last meeting on November 14<sup>th</sup>, the workgroup reviewed the November 14<sup>th</sup> draft legislation on a page-by-page basis. This document represented the next draft following the October 2nd draft developed by the drafting workgroup consisting of Paul Harrington, Steve Monahan, Mike Bertrand, Clare Buckley, John Hollar and Mike Deltrecco.

In the first section of the November 14<sup>th</sup> draft, VTDOL agreed that, in order to achieve consistency between workers' compensation and health insurance, the Rule 10 definition of medical necessity should be used instead of the Rule 40 definition. In the second section of the draft, VTDOL stated it would support changing the current 18 V.S.A. §9418 45-day timely payment standard to a 30-day standard, in order to be consistent with Rule 40 and the proposed revisions to timely payment required for health insurance (Note: John Hollar indicated by e-mail that AIA opposes the proposed 30-day standard, due to the complexity of workers' compensation).

Proposed §640((f)(5) and §640((f)(7) were revised to track the current optional penalty language in 21 VSA §688, and there was agreement that automatic interest would be assessed, consistent with the interest provisions relating to health insurance under 18

V.S.A. §9418. There was also agreement that the draft should include a 6-month medical bill filing provision upon actual knowledge that it was a workers' compensation claim. The provision reflects BISHCA's position that would bar failure to pay medical bills, unless there is prejudice to the carrier.

There was discussion regarding Dr. Neil Haas' research relating to work-related injury documentation standards. There was wide agreement that they represented an excellent standard of documentation for workers' compensation that would be highly suitable for educational seminars. However, the consensus of the working group was that the standards were too extensive for inclusion in the proposed legislation, due to the unintended consequence of potentially limiting access to health care services for injured workers due to the limited number of providers familiar with the proposed standard of documentation.

There was also discussion relating to John Hollar's recommendation to add the following section 640(h) on the denial of future medical bills relating to the same injury:

§ 640(h) Notwithstanding section 640(f), an employer or insurance carrier shall not be required to provide any notice or other response to any bill where an employer or insurance carrier has previously sent a notice to contest or deny in response to a bill for the same injury.

There was a general consensus that the proposed language was too broad for inclusion in the proposed legislation. Steve Monahan also recommended the inclusion of a new section relating to subrogation of medical bills between workers' compensation carriers and health insurance companies.

Finally, there was agreement that the Act 203 Section 27 (payment for health care services), Section 28 (processing claims, down coding and adherence to coding rules) and Section 29 (prior authorization) should apply to the workers' compensation policies of a casualty insurer. (Note: John Hollar has indicated that Travelers Insurance Company is opposed to being subject to a limitation on down coding. This is consistent with Travelers' testimony opposing a ban on down-coding during the October 3<sup>rd</sup> work group meeting.)

## Appendices

- A. Proposed Legislation
- B. IAIABC Model Act electronic medical billing for workers' compensation
- C. List of participants and minutes of meetings
- D. Background Information
  - a. Workers' Compensation Simplification Subcommittee of the Common Claims Work Group, summary of findings and recommendations.
  - b. Vermont Association of Hospitals and Health Systems: list of common workers' compensation issues.
  - c. Craig E. Goldberg, D. O., letter to Rep. Virginia Milkey, April 4, 2008.
  - d. Workers' compensation testimony, Kathy Peterson, Rutland Regional Medical Center, April 8, 2008
  - e. Neil Haas, M.D.:
    - i. Insurance Reimbursement for Workers' Compensation and Other Outpatient Services at North County Hospital
    - ii. Experiences and recommendations of Gregory Gilbert, senior vice president of reimbursement and government affairs with Concentra for expediting insurance reimbursement for workers compensation services.
    - iii. Determining causation in claims of work-related disease and injury.



(A)

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1 TO: Senator Douglas Racine, Chair, Committee on Health and Welfare  
 2 Senator Vincent Illuzzi, Chair, Committee on Economic Development, Housing  
 3 and General Affairs  
 4 Rep. Steven Maier, Chair, Committee on Health Care  
 5 Rep. Warren Kitzmiller, Chair, Committee on Commerce  
 6 FROM: Section 33, Act 203 Workers' Compensation Workgroup  
 7 RE: Draft legislation  
 8 DATE: January 15, 2009

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10 It is hereby enacted by the General Assembly of the State of Vermont:

11 **Sec. 1. 21 V.S.A. § 601 is amended to read:**

12 **§ 601. Definitions**

13 Unless the context otherwise requires, words and phrases used in this chapter  
 14 shall be construed as follows:

15 \* \* \*

16 (22) "Health care provider" shall mean a person, partnership, corporation, facility or  
 17 institution, licensed or certified or authorized by law to provide professional health care  
 18 service ~~in this state~~ to an individual during the individual's medical care, treatment or  
 19 confinement.

20 \* \* \*

21 (25) "Medical bill" means any claim, bill or request for payment for all or any portion of  
 22 provided health care services that is submitted by:

23 (A) A health care provider; or

24 (B) An injured employee who has filed a claim under this chapter.

25 (26) "Denied medical payment" or "medical bill denial" means the circumstance in which  
 26 the employer or insurance carrier:

1 (A) asserts it was not provided with sufficient information needed to determine payer  
2 liability; or

3 (B) Asserts it was not provided with reasonable access to information needed to  
4 determine the liability or basis for payment of the claim.

5 (C) asserts that it has no liability to pay a medical bill, based on eligibility status of  
6 the injured employee or coverage of a service by the employer or insurance carrier,

7 (D) asserts that the service was not reasonable or medically necessary

8 (E) asserts that another payer is liable

9 (F) or other legal or factual grounds for nonpayment.

10 Any denial based on (c)-(f) above must be supported by reasonable evidence.

11 (27) "Medically-necessary care" means health care services including diagnostic testing,  
12 preventive services and aftercare appropriate, in terms of type, amount, frequency, level,  
13 setting, and duration to the injured employee's diagnosis or condition. Medically-  
14 necessary care must be consistent with generally accepted practice parameters as  
15 recognized by health care providers in the same or similar general specialty as typically  
16 treat or manage the diagnosis or condition, and

- 17 1. Help restore or maintain the injured employee's health; or
- 18 2. Prevent deterioration of or palliate the injured employee's condition; or
- 19 3. Prevent the reasonably likely onset of a health problem or detect an incipient  
20 problem.

21 **Sec. 2. 21 V.S.A. § 640(f), and (g) are added to read:**

22 (f) **Submission of medical bills; payment.** No later than 30 days following receipt of a  
23 bill for medical, surgical, hospital and nursing services and supplies, prescription drugs,  
24 and durable medical equipment provided to an injured employee from a health care  
25 provider, an employer or an insurance carrier shall do one of the following:

26 (1) Pay or reimburse the medical bill.

27 (2) Notify the injured employee, the health care provider and the commissioner in writing  
28 that the medical bill is contested or denied. The notice shall be in writing and include  
29 specific reasons supporting the contest or denial and a description of any additional  
30 information required for the employer or insurance carrier to determine liability for the  
31 medical bill.

32 (3) Disputes regarding any medical bills under this subsection may be filed with the  
33 commissioner by the injured employee or health care provider and the disputes shall be

1 resolved pursuant to the provisions of this chapter, or, any dispute concerning payment of  
2 a medical bill or interest on a medical bill, arising out of or relating to the provisions of  
3 this section shall, at the option of either party, be settled by arbitration in accordance with  
4 the Commercial Rules of the American Arbitration Association, and judgment upon the  
5 arbitrator's award may be entered in any court having jurisdiction. The commissioner  
6 shall be provided with a copy of any arbitration decision.

7 (4) If a medical bill is denied because the employer or insurance carrier was not provided  
8 with sufficient information to determine payer liability and for which written notice has  
9 been provided as required by subdivision (2) of this subsection, then the employer or  
10 insurance carrier shall have 30 days after receipt of the requested additional information  
11 to complete consideration of the medical bill.

12 (5) The commissioner may assess penalties as provided for in section 688 of this chapter  
13 against an employer or an insurance carrier that fails to comply with the provisions of this  
14 subsection or any order of the commissioner.

15 (6) Interest shall accrue on a medical bill at the rate of 12 percent per annum calculated as  
16 follows:

17 (A) For a medical bill that is not denied within 30 days, from the first calendar day  
18 following the date the medical bill is received by the employer or insurance carrier.

19 (B) For a denied medical bill, for which notice was provided as required by this  
20 subsection, from the first calendar day after the 30-day period following the date that  
21 sufficient additional information is received.

22 (C) For a denied medical bill for which notice was not provided as required by this  
23 section or for which notice was provided later than the 30 days required by subdivision  
24 (2) of this subsection, from the first calendar day after the 30-day period following the  
25 date the original medical bill was received by the employer or an insurance carrier.

26 (D) For a medical bill that was denied, from the first calendar day after the 30-day period  
27 following the date of a final arbitration award, judgment or administrative order that  
28 found the employer or insurance carrier to be liable for payment of the medical bill.

29 (E) The commissioner may suspend the accrual of interest under this subdivision if the  
30 commissioner determines that the employer or insurance carrier's failure to pay a medical  
31 bill within the applicable time limit is the result of a major disaster, act-of-God or  
32 unanticipated major computer system failure or that the action is necessary to protect the  
33 solvency of the employer or insurance carrier or to protect the public good.

34 (F) All payments shall be made within the time periods provided by this subsection  
35 unless otherwise specified in a contract between the employer or insurance carrier and the  
36 health care provider. If a contract describes a different time period, the employer or  
37 insurance carrier shall provide notice as required by subdivision (2) of this subsection and

1 pay interest on as required in this subdivision from the day following the contract  
2 payment period, unless otherwise specified in the contract.

3 (7) If the commissioner finds that an employer or an insurance carrier has engaged in a  
4 pattern and practice of violating this subsection, the commissioner may impose an  
5 additional administrative penalty against the health plan of no more than \$500.00 for each  
6 violation. In determining the amount of penalty to be assessed, the commissioner shall  
7 consider the following factors:

8 (A) The appropriateness of the penalty with respect to the financial resources and good  
9 faith of the employer or insurance carrier.

10 (B) The gravity of the violation or practice.

11 (C) The history of previous violations or practices of a similar nature.

12 (D) The economic benefit derived by the employer or insurance carrier and the economic  
13 impact on the health care provider resulting from the violation.

14 (E) Any other relevant factors.

15 (8) In addition to assessing administrative penalties, the commissioner may refer to the  
16 commissioner of banking, insurance, securities and health care administration any  
17 employer or insurance carrier which neglects or refuses to properly pay medical bills in  
18 accordance with the provisions of this chapter.

19 (9) Any interest or penalty paid by an employer or insurance carrier under this chapter  
20 shall be excluded from the claims data reported pursuant to 8 V.S.A. § 4687.

21 (10) A health care provider shall submit the medical bill for the services provided to the  
22 injured employee, with supporting medical documentation, to the employer or insurance  
23 carrier within 6 months of the date the health care provider had actual knowledge the  
24 services relate to a workers' compensation claim. Failure to submit the medical bill  
25 within the time limit shall not bar payment of the bill, unless there was prejudice to an  
26 employer or an insurance carrier. The commissioner may suspend the 6-month time limit  
27 if the commissioner determines that the health care provider's failure to submit the  
28 medical bill within the applicable time limit is the result of circumstances outside the  
29 control of the health care provider.

30 **(g) Medical documentation.** "Medical documentation" means documentation that  
31 describes the injury and treatment provided, including treatment notes, medical records  
32 and diagnostic codes, and is sufficiently detailed to allow for the review of the medical  
33 necessity of the service and the appropriateness of the fee charged. At a minimum,  
34 medical bills for payment submitted under subsection (f) of this section shall:

35 (1) Be submitted in appropriate electronic or paper format as follows:

- 1           (A) CMS 1500 or its electronic equivalent for medical;  
2           (B) UB04 or its electronic equivalent for hospital inpatient and outpatient services;  
3           (C) ADA J515 or its electronic equivalent for dental services.

- 4  
5           (2) Every field or data element relevant to a particular treatment is completed.  
6           (3) Treatment coding conforms to the criteria of the National Correct Coding Initiative.  
7           (4) Medical documentation is in legible form and it includes all relevant medical reports  
8           and records.

9  
10   **Sec. 3. 21 V.S.A. § 682 is amended to read:**

11  
12   **§ 682. Liens against compensation**

13           (a) Claims of physicians and hospitals for services rendered under the provisions  
14           of this chapter, or health insurers as defined under 18 V.S.A. § 9402(8) paying a  
15           claim of physicians and hospitals for such services, and claims of attorneys for  
16           services rendered an employee in prosecuting a claim under the provisions of this  
17           chapter shall be approved by the commissioner. When so approved they may be  
18           enforced against compensation awards in such manner as the commissioner may  
19           direct.

20           (b) A health insurer that pays a claim determined to be covered by an employers or  
21           insurance carrier shall seek reimbursement from said employers or insurance carrier. The  
22           health insurer and the employer or insurance carrier shall not have a claim against  
23           physicians and hospitals or an employee for such payments, unless so ordered by the  
24           commissioner.  
25

26   **Sec. 4. 18 V.S.A. § 9418 is amended to read:**

27           **§ 9418. Payment for health care services**

28           (a) As used in this section,

29           (1) "Health plan" means a health insurer, disability insurer, health maintenance  
30           organization, medical or hospital service corporation ~~or a workers' compensation policy~~  
31           ~~of a casualty insurer~~ licensed to do business in Vermont. "Health plan" also includes a  
32           health plan that requires its medical groups, independent practice associations or other  
33           independent contractors to pay claims for the provision of health care services.

34           (2) "Claim" means any claim, bill or request for payment for all or any portion of  
35           provided health care services that is submitted by:

36           (A) A health care provider or a health care facility pursuant to a contract or agreement  
37           with the health plan; or

1 (B) A health care provider, a health care facility or a patient covered by the health plan.

2 (3) "Contest" means the circumstance in which the health plan was not provided with:

3 (A) Sufficient information needed to determine payer liability; or

4 (B) Reasonable access to information needed to determine the liability or basis for  
5 payment of the claim.

6 (4) "Denied" or "denial" means the circumstance in which the plan asserts that it has no  
7 liability to pay a claim, based on eligibility status of the patient, coverage of a service  
8 under the health plan, medical necessity of a service, liability of another payer or other  
9 grounds.

10 (b) No later than 45 days following receipt of a claim, a health plan shall do one of the  
11 following:

12 (1) Pay or reimburse the claim.

13 (2) Notify the claimant in writing that the claim is contested or denied. The notice shall  
14 include specific reasons supporting the contest or denial and a description of any  
15 additional information required for the health plan to determine liability for the claim.

16 ~~(e) If the claim submitted is to a health plan that is a workers' compensation insurance~~  
17 ~~policy;~~

18 ~~(1) The health plan shall within 45 days following receipt of the claim:~~

19 ~~(A) pay or reimburse the claim; or~~

20 ~~(B) notify in writing the claimant and the commissioner of labor that the claim is~~  
21 ~~contested or denied. The notice shall include specific reasons supporting the contest or~~  
22 ~~denial and a description of any additional information required for the health plan to~~  
23 ~~determine liability for the claim.~~

24 ~~(2) Disputes regarding any claims under this subsection shall be resolved pursuant to the~~  
25 ~~provisions of chapters 9 and 11 of Title 21.~~

26 ~~(3) The commissioner of labor may assess interest and penalties as provided in~~  
27 ~~subsections (e) and (f) of this section against a health plan that fails to comply with the~~  
28 ~~provisions of this section or any order of the commissioner. These remedies are in~~  
29 ~~addition to any other penalties available under Title 8 and chapters 9 and 11 of Title 21.~~

30 ~~(d)~~ (c) If a claim is contested because the health plan was not provided with sufficient  
31 information to determine payer liability and for which written notice has been provided

1 as required by subdivision (b)(2) of this section, then the health plan shall have 45 days  
2 after receipt of the additional information to complete consideration of the claim.

3 ~~(e)~~ (d) Interest shall accrue on a claim at the rate of 12 percent per annum calculated as  
4 follows:

5 (1) For a claim that is uncontested, from the first calendar day following the 45-day  
6 period following the date the claim is received by the health plan.

7 (2) For a contested claim, for which notice was provided as required by this section, from  
8 the first calendar day after the 45-day period following the date that sufficient additional  
9 information is received.

10 (3) For a contested claim for which notice was not provided as required by this section or  
11 for which notice was provided later than the 45 days required by subdivision (b)(2) of  
12 this section, from the first calendar day after the 45-day period following the date the  
13 original claim was received by the health plan.

14 (4) For a claim that was denied, from the first calendar day after the 45-day period  
15 following the date of a final arbitration award, judgment or administrative order that  
16 found a plan to be liable for payment of the claim.

17 ~~(f)~~ (e) The commissioner may suspend the accrual of interest under subsection ~~(e)~~ (d) if  
18 the commissioner determines that the health plan's failure to pay a claim within the  
19 applicable time limit is the result of a major disaster, act-of-God or unanticipated major  
20 computer system failure or that the action is necessary to protect the solvency of the  
21 health plan.

22 ~~(g)~~ (f) All payments shall be made within the time periods provided by this section unless  
23 otherwise specified in the contract between the health plan and the health care provider or  
24 the health care facility. The health plan shall provide notice as required by subsection (b)  
25 of this section and pay interest on uncontested and contested claims as required in  
26 subsection ~~(d)~~ (c) of this section from the day following the contract payment period,  
27 unless otherwise specified in the contract.

28 ~~(h)~~ (g) Any dispute concerning payment of a claim or interest on a claim, arising out of or  
29 relating to the provisions of this section shall, at the option of either party, be settled by  
30 arbitration in accordance with the Commercial Rules of the American Arbitration  
31 Association, and judgment upon the arbitrator's award may be entered in any court  
32 having jurisdiction.

33 ~~(i)~~ (h) If the commissioner finds that a health plan has engaged in a pattern and practice  
34 of violating this section, the commissioner may impose an administrative penalty against  
35 the health plan of no more than \$500.00 for each violation. In determining the amount of  
36 penalty to be assessed, the commissioner shall consider the following factors:

1 (1) The appropriateness of the penalty with respect to the financial resources and good  
2 faith of the health plan.

3 (2) The gravity of the violation or practice.

4 (3) The history of previous violations or practices of a similar nature.

5 (4) The economic benefit derived by the health plan and the economic impact on the  
6 health care facility or health care provider resulting from the violation.

7 (5) Any other relevant factors.

8  
9

\* \* \*

10  
11 (n) The provisions of this section shall not apply to stand-alone dental plans ~~or to a~~  
12 ~~workers' compensation policy of a casualty insurer~~ licensed to do business in Vermont.  
13

14 **Sec. 5. 18 V.S.A. § 9418a. is amended to read:**

15 **Processing claims, downcoding, and adherence to coding rules**

16 **§ 9418a**

17 (a) As used in this section:

18 (1) "Claim" means any claim, bill, or request for payment for all or any portion of  
19 provided health care services that is submitted by:

20 (A) A health care provider or a health care facility pursuant to a contract or  
21 agreement with the health plan; or

22 (B) A health care provider, a health care facility, or a patient covered by the  
23 health plan.

24 (2) "Contest" means the circumstance in which the health plan was not provided  
25 with:

26 (A) Sufficient information needed to determine payer liability; or

27 (B) Reasonable access to information needed to determine the liability or basis for  
28 payment of the claim.

29 (3) "Health plan" means a health insurer, disability insurer, health maintenance  
30 organization, or medical or hospital service corporation, but does not include a  
31 stand-alone dental plan ~~or a workers' compensation policy of a casualty insurer~~

1 licensed to do business in Vermont. "Health plan" also includes a health plan that  
2 requires its medical groups, independent practice associations, or other  
3 independent contractors to pay claims for the provision of health care services.

4 **Section 6. 18 V.S.A. § 9418b is amended to read:**

5 **Prior authorization**

6 (a) As used in this section:

7 (1) "Claim" means any claim, bill, or request for payment for all or any portion of  
8 provided health care services that is submitted by:

9 (A) A health care provider or a health care facility pursuant to a contract or  
10 agreement with the health plan; or

11 (B) A health care provider, a health care facility, or a patient covered by the  
12 health plan.

13 (2) "Health plan" means a health insurer, disability insurer, health maintenance  
14 organization, or medical or hospital service corporation but does not include a  
15 stand-alone dental plan ~~or a workers' compensation policy of a casualty insurer~~  
16 licensed to do business in Vermont. "Health plan" also includes a health plan that  
17 requires its medical groups, independent practice associations, or other  
18 independent contractors to pay claims for the provision of health care services.



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## MODEL ACT ELECTRONIC MEDICAL BILLING FOR WORKERS' COMPENSATION

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### Section 1. Purpose

- A. The purpose of this Act is to provide for billing, processing, and payment for medical compensation provided to injured employees subject to (insert state statute, chapter number, or other appropriate reference to state statutes).

**DRAFTING OPTION:** Insert after compensation, "and data reporting" for jurisdictions who wish to mandate electronic data reporting of medical compensation.

### Section 2. Definitions

- A. For the purposes of this Act the following definitions shall apply:
  - (1) "Bill review" means review of any aspect of a medical bill in accordance with the (insert reference to state law, administrative rules, or fee schedules as applicable).
  - (2) "Complete medical bill" means a medical bill that contains all required fields as set forth in the billing instructions for the appropriate form specified in Section 3 of this Act.
  - (3) "Health care provider agent" means a person or entity that the health care provider contracts with or utilizes for the purpose of fulfilling the health care provider's obligations for medical bill processing under the (insert reference to state law, administrative rules, or fee schedules as applicable).

- (4) “Employer, insurance carrier, or managed care organization agent” means a person or entity that the employer, insurance carrier, or managed care organization contracts with or utilizes for the purpose of providing claims services or fulfilling the employer’s, insurance carrier’s or managed care organization’s obligations for medical bill processing under the (insert reference to state law, administrative rules, or fee schedules as applicable).

**DRAFTING OPTION:** Insert after processing “and data reporting”.

- (5) “Pharmacy processing agent” means a person or entity that contracts with a pharmacy in accordance with (insert reference to state law, administrative rules, or fee schedules as applicable) establishing an agent or assignee relationship, to process claims and act on behalf of the pharmacy under the terms and conditions of a contract related to services being billed. Such contracts may permit the agent or assignee to submit billings, request reconsideration, receive reimbursement, and seek medical dispute resolution for the pharmacy services billed.
- (6) “Commission (or other similar term)” means the (insert reference to state workers’ compensation agency) responsible for administering the (insert reference to state law).

### **Section 3. Electronic Formats for Electronic Medical Bill Processing**

- A. The (insert reference to state workers’ compensation agency) prescribes standard electronic formats by adopting the following implementation guides for the medical billing transactions:

- (1) Billing:
- (a) Professional Billing – The ASC X12N 837—Health Care Claim: Professional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X098 and Addenda to Health Care Claim: Professional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X098A1, as referenced in §162.1102 and §162.1802.
- (b) Institutional/Hospital Billing – The ASC X12N 837—Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X096 and Addenda to Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X096A1 as referenced in §162.1102 and §162.1802.

- (c) Dental Billing – The ASC X12N 837—Health Care Claim: Dental, Version 4010, May 2000, Washington Publishing Company, 004010X097 and Addenda to Health Care Claim: Dental, Version 4010, October 2002, Washington Publishing Company, 004010X097A1, as referenced in §162.1102 and §162.1802.
- (d) Pharmacy Billing – The Telecommunication Standard Implementation Guide Version 5, Release 1 (Version 5.1), September 1999, National Council for Prescription Drug Programs, and the Batch Standard Batch Implementation Guide, Version 1, Release 1 (Version 1.1), January 2000, supporting Telecommunication Standard Implementation Guide, Version 5, Release 1 (Version 5.1) for the NCPDP Data Record in the Detail Data Record, National Council for Prescription Drug Programs

(2) Acknowledgment:

- (a) Functional Acknowledgment – ANSI x12 997 Version 4010.
- (b) Detail Acknowledgment – ANSI x12 824 Version 4010.

- (3) Remittance – The ASC X12N 835—Health Care Claim Payment/Advice, Version 4010, May 2000, Washington Publishing Company, 004010X091, and Addenda to Health Care Claim Payment/Advice, Version 4010, October 2002, Washington Publishing Company, 004010X091A1

- (4) Reporting – IAIABC 837 Version 4010.

- (5) Documentation – ANSI x12 275 Version 4050.

B. An implementation guide is a:

- (1) Specification document for national standard electronic formats as defined in Section A. of this section and published by a national standard setting organization that defines data requirements, data transaction sets, and data mapping; or
- (2) Published specification document that defines specific data requirements, data set transactions, data mapping, or data edits and is intended to accompany national standard implementation guides.

C. Codes and modifier contained in the **(insert reference to state law, administrative rules, or fee schedules as applicable)** are valid codes for these workers' compensation transactions in addition to any national code sets used by the adopted implementation guides. Except for these limited code set exceptions, entities involved in transaction processing must comply with all applicable federal laws related to electronic health claims, including implementation guides and code sets.

D. Medical billing transactions must:

- (1) Contain all fields required in the applicable format implementation guide as set forth in Section A. and associated (insert reference to state law, administrative rules, or fee schedules as applicable); and
  - (2) be populated with current and correct values defined in the applicable implementation guide as set forth in Section A. and B. and associated (insert reference to state law, administrative rules, or fee schedules as applicable).
- E. Employers, insurance carriers, managed care organizations or their agents and health care providers or their agents may exchange electronic data in a non- (insert state workers' compensation agency name) prescribed format by mutual agreement. All data elements required in the (insert state workers' compensation agency name) prescribed formats must be present in a mutually agreed upon format. Any non-(insert state workers' compensation agency name) prescribed formats must be fully compliant with medical electronic data interchange requirements adopted by (insert state workers' compensation agency name) in Section 7 of this Act.

#### Section 4. Electronic Medical Billing, Reimbursement, and Documentation

##### A. Applicability

- (1) This section is the exclusive process to exchange medical bill data in accordance with Section 3 (relating to Electronic Formats for Electronic Medical Bill Processing) for professional, institutional/hospital, pharmacy, and dental services. This section does not apply to health care provider, employer, insurance carrier, managed care organization, or their agents' requests for reconsideration or appeals concerning any matter related to medical compensation or requests for informational copies of medical records.
- (2) Unless the employer or insurance carrier is excepted from the process in accordance with paragraph (6) of this subsection, employers or insurance carriers, shall:
  - (a) Accept electronic medical bill submitted in accordance with the adopted standards;
  - (b) Transmit acknowledgements and remittance advice in compliance with the adopted standards in response to electronically submitted medical bills; and
  - (c) Support all means of electronic document submission related to electronically submitted medical bills as defined by Subsection A(a)(4) and subsection (e) below.
- (3) Unless the health care provider is excepted from the process in accordance with paragraph (5) of this subsection, a health care provider must:

- (a) implement a software system capable of exchanging medical bill data in accordance with the adopted standards;
  - (b) electronically submit medical bills to any payers that have established connectivity to the health care provider's system or clearinghouse; and
  - (c) electronically submit required documentation in accordance with subsection (3) below.
- (4) Health care providers, employers, insurance carriers, and managed care organizations may contract with other entities for electronic medical bill processing. Employers, insurance carriers, managed care organizations, and health care providers are responsible for the acts or omissions of their agents executed in the performance of electronic medical bill processing.
- (5) A health care provider is waived from the requirement to submit medical bills electronically to an insurance employer, insurance carrier, managed care organization or their agents if:
- (a) The health care provider employs ten (10) or fewer full time employees, and workers' compensation constitutes less than 10% of their practice.

**DRAFTING OPTION:**

May use different standard to determine whether health care provider may be excepted from electronic medical billing requirement such as:

- (a) Only use number of full-time employees in practice (Used by Medicare).
- (b) The health care provider submitted less than (insert number) bills for workers' compensation treatment in the previous calendar year.

**DRAFTING OPTION:**

May insert a different subsection regarding approval of individual waivers:

"The health care provider requests and the (insert state workers' compensation agency name) approves a waiver. The (insert state workers' compensation agency name) will approve a request on a case-by-case basis and will base the decision on whether or not electronic billing causes an unreasonable financial burden on the health care provider."

- (6) An employer, insurance carrier, managed care organization or their agents are waived from the requirement to receive medical bills electronically from health care providers if:

- (a) The employer, insurance carrier, or managed care organization processed less than (insert number i.e. 250) workers' compensation related medical bills in the previous calendar year.

**DRAFTING OPTION:** May insert a different subsection regarding approval of individual waivers: "The (insert state workers' compensation agency name) may grant an exception on a case-by-case basis if an insurance employer, insurance carrier, managed care organization or their agents, establishes that electronic billing will result in an unreasonable financial burden."

**B. Electronic medical bill**

- (1) An electronic medical bill is a medical bill submitted electronically by a health care provider or an agent of the health care provider.
- (2) A complete electronic medical bill is an electronic medical bill that:
- (a) Is submitted in accordance with this chapter, and
  - (b) Identifies the:
    - (i) Injured employee;
    - (ii) Employer;
    - (iii) Employer, insurance carrier, managed care organization or their agents;
    - (iv) Health care provider; and
    - (v) Service, supply, or medication.
- (3) The received date of an electronic medical bill is the date the bill is electronically transmitted in accordance with the implementation guide. An electronic medical bill is considered received if it meets the criteria of a complete electronic medical bill.

**C. Acknowledgment**

- (1) A Functional Acknowledgment is an electronic notification to the sender of an electronic file that the file has been received and:
- (a) Accepted as a complete, correct file, or
  - (b) Rejected with a valid rejection code.
- (2) A Detail Acknowledgment is an electronic notification to the sender of an electronic transaction within an electronic file that the transaction has been received and:
- (a) Accepted as a complete, correct submission, or
  - (b) Rejected with a valid rejection code.

- (3) An insurance employer, insurance carrier, managed care organization or their agents must acknowledge receipt of an electronic medical bill by returning a Detail Acknowledgment within one (1) business day of receipt of the electronic submission.
  - (a) Notification of a rejection is transmitted in a Detail Acknowledgment when an electronic medical bill does not meet the definition of a complete electronic medical bill or does not meet the edits defined in the applicable implementation guide or guides.
  - (b) A health care provider may not submit a duplicate electronic medical bill earlier than forty-five (45) days from the date submitted if an employer, insurance carrier, managed care organization or their agents has acknowledged acceptance of the original complete electronic medical bill. A health care provider may submit a corrected medical bill electronically to the insurance employer, insurance carrier, managed care organization or their agents after receiving notification of a rejection. The corrected medical bill is submitted as a new, original bill.
- (4) Acceptance of a complete medical bill is not an admission of liability by the employer, insurance carrier, managed care organization or their agents. An employer, insurance carrier, managed care organization or their agents may subsequently reject an accepted electronic medical bill if it is determined that the employer listed on the medical bill is not a policyholder of the employer, insurance carrier, managed care organization or their agents.
  - (a) The subsequent rejection must occur no later than seven (7) days from the date of receipt of the complete electronic medical bill.
  - (b) The rejection transaction must clearly indicate the reason for the rejection is due to denial of liability.
- (5) Acceptance of an incomplete medical bill does not satisfy the written notice of injury requirement from an employee, employer, insurance carrier, or their agents as required in (insert reference to state workers' compensation statute).
- (6) Acceptance of a complete or incomplete medical bill by an employer, insurance carrier, or their agents does not begin the time period by which an employer, insurance carrier, or their agents must admit or deny liability for any alleged claim related to such medical treatment pursuant to (insert reference to state workers' compensation statute).

D. Electronic remittance notification

- (1) An electronic remittance notification is an explanation of benefits (EOB),

submitted electronically regarding payment or denial of a medical bill, recoupment request, or receipt of a refund.

- (2) An insurance carrier must provide an electronic remittance notification no later than thirty (30) days after receipt of a complete electronic medical bill or within five (5) days of generating a payment.

**E. Electronic documentation**

- (1) Electronic documentation consists of medical reports and/or records submitted electronically that are related to an electronic medical bill that are required before payment may be remitted to the healthcare provider.
- (2) Complete electronic documentation related to an electronic medical bill:
  - (a) Is submitted by fax, electronic mail, or in an electronic format and
  - (b) Identifies the:
    - (i) Injured employee,
    - (ii) Employer, insurance carrier, managed care organization or their agents;
    - (iii) Health care provider;
    - (iv) Related medical bill(s), and
    - (v) Date(s) of service.

**DRAFTING OPTION:** Other data elements may be added to this list.

- (3) When a health care provider submits electronic documentation related to an electronic medical bill, the documentation must be submitted within seven (7) days of submission of the electronic medical bill.

**DRAFTING OPTION:** Add the following: Electronic documentation may be submitted simultaneously with the electronic medical bill.

**DRAFTING OPTION:** Add the following: Electronic documentation may be submitted separately from the electronic medical bill within seven (7) days of successful submission of the electronic medical bill.

**F. Health care providers excepted from electronic medical billing pursuant to subsection A. (5) shall submit paper medical bills for payment in the following formats as applicable:**

- (1) On the current standard forms used by the Centers for Medicare and Medicaid Services (CMS);
- (2) On the current National Council for Prescription Drug Programs (NCPDP) Universal Claim Form (UCF)

(3) On the current American Dental Association (ADA) Claim Form

All information submitted on required paper billing forms must be legible and completed in accordance with (insert state workers' compensation agency name) instructions.

- G. Unless the employer or insurance carrier is excepted from the electronic medical billing process in accordance with Section 4 (relating to Electronic Medical Billing, Reimbursement, and Documentation), an insurance carrier must establish connectivity to any clearinghouse that requests the exchange of data in accordance with Section 3 (relating to Electronic Formats for Electronic Medical Bill Processing), subject to paragraph B. of this section.
- H. An insurance carrier or clearinghouse that requests another insurance carrier or clearinghouse to receive, process, or transmit a standard transaction may not charge fees or costs in excess of the fees or costs for normal telecommunications that the entity incurs when it directly transmits, or receives, a standard transaction.
- I. An insurance carrier or their agent may not reject a standard transaction on the basis that it contains data elements not needed or used by the insurance carrier or agent.
- J. A health care provider that has not implemented a software system capable of sending standard transactions is required to use an Internet based, direct data entry system offered by an insurance carrier if the insurance carrier does not charge a transaction fee. A health care provider using an Internet based, direct data entry system offered by an insurance carrier or other entity must use the appropriate data content and data condition requirements of the standard transactions.
- K. The employer, insurance carrier, managed care organization or their agents' failure to comply with any requirements of this law/rule shall result in an administrative violation.

**Section 5. Employer, Insurance Carrier, Managed Care Organization or Agents' Receipt of Medical Bills from Health Care Providers**

- A. Upon receipt of medical bills submitted in accordance with Section 3 (relating to Electronic Billing Medical Forms/Formats), an employer, insurance carrier, managed care organization or their agents shall evaluate each medical bill for completeness as defined in Section 3 (relating to Electronic Billing Medical Forms/Formats).
  - (1) Employers, insurance carriers, managed care organizations or their agents, shall not return medical bills that are complete, unless the bill is a duplicate bill.
  - (2) Within twenty-one (21) days after the day it receives a medical bill that is not complete as defined in Section 4 (relating to Electronic Medical Billing, Reimbursement, and Documentation), an employer, insurance carrier, managed care organization or their agents shall:

- (a) Complete the bill by adding missing information already known to the employer, insurance carrier, managed care organization or their agents except for the following:
  - (i) Dates of service;
  - (ii) Procedure/modifier codes;
  - (iii) Number of units; and
  - (iv) Charges; or
- (b) Return the bill to the sender, in accordance with subsection C.

- (3) The employer, insurance carrier, managed care organization or their agents may contact the sender to obtain the information necessary to make the bill complete, including the information specified in paragraph (2)(A)(i) - (iv) of this subsection. If the employer, insurance carrier, managed care organization or their agents obtain the missing information and completes the bill, the employer, insurance carrier, managed care organization or their agents shall document the name and telephone number of the person who supplied the information.

B. For purposes of bills submitted for payment for medical services for treatments rendered under (insert reference to state law, administrative rules, or fee schedules as applicable), a bill will be considered adequate for the determination of the timely payment, as defined in Section 4 (relating to Electronic Medical Billing, Reimbursement, and Documentation), provided that it meets all of the following criteria:

- (1) the bill is submitted on the appropriate electronic or paper format as follows:
  - (a) CMS 1500 for medical;
  - (b) UB04 for hospital inpatient and outpatient services;
  - (c) ADA J515 for dental services

**DRAFTING NOTE: state defined standard billing forms which will generally be the CMS standard billing form.**

**DRAFTING NOTE: other forms may be prescribed for pharmacy and other services such as med legal.**

- (2) every field or data element relevant to a particular treatment is completed. This includes:

**DRAFTING NOTE: (states should prescribe the data elements that are to be required fields on to complete the forms)**

- (3) codes used for treatment and diagnosis are recognized as valid for the period of service rendered by [cite the state];
- (4) treatment coding conforms to the criteria of the National Correct Coding Initiative, unless superseded by state exceptions or modifications.

**DRAFTING NOTE: Many states that use Medicare based fee schedules have adopted coding systems that are out of alignment with the most current versions of the CMS coding and rules. These exceptions usually amount to a small fraction of the bills.**

- B. Payers must timely reject bills or request additional information needed to reasonably determine the amount payable.
- (1) For bills submitted electronically, the rejection of all or part of the bill must be sent to the submitter within two working days of receipt.
  - (2) If bills are submitted in a batch transmission, only the specific bills failing edits shall be rejected.
- C. If a payer has reason to challenge the coverage or amount of a specific line item on a bill, but has no reasonable basis for objections to the remainder of the bill, the uncontested portion must be paid timely.
- D. Timely payment of all uncontested portions of a bill shall be made within 30 days of receipt of the original bill, or receipt of additional information requested by the payer allowed under the law. Amounts paid after this 30 day review period shall accrue an interest penalty of \_\_\_\_\_ percent per month after the due date. The interest payment must be made at the same time as the medical bill payment.
- E. An employer, insurance carrier, managed care organization or their agents shall not return a medical bill except as provided in subsection (a) of this section. When returning a medical bill, the employer, insurance carrier, managed care organization or their agents shall include a document identifying the reason(s) for returning the bill. The reason(s) related to the procedure or modifier code(s) shall identify the reason(s) by line item.
- F. The proper return of an incomplete medical bill in accordance with this section fulfills the employer's, insurance carrier's, managed care organization's or their agents' obligations with regard to the incomplete bill.
- G. An employer, insurance carrier, managed care organization or their agents shall not combine bills submitted in separate envelopes as a single bill or separate single bills spanning several pages submitted in a single envelope.
- H. An employer, insurance carrier, managed care organization or their agents shall convert any non-electronic medical bills or medical documentation received from a health care provider or their agent in the form and format required for medical electronic data interchange to the (insert state workers' compensation agency name) in compliance with Section 7 of this Act.
- I. The employer, insurance carrier, managed care organization or their agents' failure to comply with any requirements of this law/rule shall result in an administrative violation.

**Section 6. Communication Between Health Care Providers and Employer, Insurance Carrier, Managed Care Organization or Their Agents**

- A. Any communication between the health care provider and employer, insurance carrier, managed care organization or their agents related to medical bill processing shall be of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as "employer, insurance carrier, managed care organization or their agents improperly reduced the bill" or "health care provider did not document" or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this Section.
- B. Communication between the health care provider and employer, insurance carrier, managed care organization or their agents related to medical bill processing shall be made by telephone or electronic transmission unless the information cannot be sent by those media, in which case the sender shall send the information by mail or personal delivery.
- C. Health care providers and employer, insurance carrier, managed care organization or their agents, shall maintain, in a reproducible format, documentation of communications related to medical bill processing.
- D. The employer, insurance carrier, managed care organization or their agents' failure to comply with any requirements of this law/rule shall result in an administrative violation.

**Section 7. Effective Date**

- A. This chapter applies to all medical compensation provided on or after **(insert date)**. For medical compensation provided prior to **(insert date)**, medical billing and processing shall be in accordance with the Sections in effect at the time the medical compensation was provided.

**OPTIONAL ADDITIONAL ITEMS TO INCLUDE**

**Section \_\_\_\_ . Employer, Insurance Carrier, Managed Care Organization or Their Agents Medical Electronic Data Interchange to the (insert state workers' compensation agency name)**

- A. The employer, insurance carrier, managed care organization or their agents shall submit medical bills, all medical bill attachments, and payment data to the **(insert state workers' compensation agency name)** within ten (10) days of receipt of any data from a health care provider and after the employer, insurance carrier, managed care organization or their agents makes payment, denies payment, or receives a refund of overpayment on a medical bill.

- B. Employer, insurance carrier, managed care organization or their agents, shall submit medical bill and payment data electronically in the form and format prescribed by the (insert state workers' compensation agency name).
- C. The (insert state workers' compensation agency name) shall prescribe the form, format, and content of the required medical bill and payment data submission.
- D. This section shall apply to all medical compensation provided on or after (insert date).
- E. The employer, insurance carrier, managed care organization or their agents' failure to comply with any requirements of this law/rule shall result in an administrative violation.

**Section \_\_\_\_ . Preauthorization of Health Care  
(Optional)**

- A. The employer, insurance carrier, managed care organization or their agents shall designate accessible direct telephone and facsimile numbers and may designate an electronic transmission address for use by the requesting health care provider or employee to request preauthorization during normal business hours. The direct number shall be answered or the facsimile or electronic transmission address responded to by the employer, insurance carrier, managed care organization or their agents within the time limits established in subsection C. of this section.
- B. The requesting health care provider or employee shall request and obtain preauthorization from the employer, insurance carrier, managed care organization or their agents prior to providing or receiving health care subject to the requirements of NCGS §97-25.3, "Preauthorization". The request for preauthorization shall be sent to the employer, insurance carrier, managed care organization or their agents by telephone, facsimile, or electronic transmission and, include the:
  - (1) Specific health care;
  - (2) Number of specific health care treatments and the specific period of time requested to complete the treatments;
  - (3) Information to substantiate the medical necessity of the health care requested;
  - (4) Accessible telephone and facsimile numbers and may designate an electronic transmission address for use by the employer, insurance carrier, managed care organization or their agents;
  - (5) Name of the provider performing the health care; and
  - (6) Facility name and estimated date of proposed health care.
- C. The employer, insurance carrier, managed care organization or their agents shall notify the requesting health care provider or employee by telephone, facsimile, or electronic transmission with the decision to approve or deny the request within two (2) working days of receipt of a request for preauthorization; or

- D. The employer, insurance carrier, managed care organization or their agents shall send written notification by facsimile or electronic transmission of the approval or denial of the request within one (1) working day of the decision to the:
- (1) Employee;
  - (2) Employee's representative; and
  - (3) Requesting health care provider, if not previously sent by facsimile or electronic transmission.
- E. The employer, insurance carrier, managed care organization or their agents shall not withdraw a preauthorization approval once issued. The approval shall include:
- (1) The specific health care; and
  - (2) The approved number of health care treatments and specific period of time to complete the treatments;
- F. The employer, insurance carrier, managed care organization or their agents shall afford the requesting health care provider a reasonable opportunity to discuss the clinical basis for a denial with the appropriate doctor or health care provider performing the review prior to the issuance of a preauthorization. The denial shall include:
- (1) The clinical basis for the denial;
  - (2) A description or the source of the screening criteria that were utilized as guidelines in making the denial;
  - (3) The principle reasons for the denial, if applicable;
- G. The employer, insurance carrier, managed care organization or their agents shall not condition an approval or change any elements of the request as listed in subsection B. of this section, unless the condition or change is mutually agreed to by the health care provider and employer, insurance carrier, managed care organization or their agents and is documented.
- H. The employer, insurance carrier, managed care organization or their agents shall maintain accurate records to reflect information regarding requests for preauthorization and appeals, if any. The employer, insurance carrier, managed care organization or their agents shall submit such information in the form and manner prescribed by the (insert state workers' compensation agency name).
- I. The employer, insurance carrier, managed care organization or their agents' failure to comply with any timeframe requirements of this section shall result in an administrative violation.

Section \_\_\_\_ Medical Documentation Necessary for Billing Adjudication  
(Optional)

- A. Medical documentation includes all medical reports and records, such as evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records and diagnostic test results.
- B. When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form, unless the required documentation was previously provided to the employer, insurance carrier, managed care organization or their agents.
- C. Any request by the employer, insurance carrier, managed care organization or their agents for additional documentation to process a medical bill shall:
- (1) Be in writing;
  - (2) Be specific to the bill or the bill's related episode of care;
  - (3) Describe with specificity the clinical and other information to be included in the response;
  - (4) Be relevant and necessary for the resolution of the bill;
  - (5) Be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider that has not previously been submitted as medical documentation in the electronic billing transaction at issue;
  - (6) Indicate the specific reason for which the employer, insurance carrier, managed care organization or their agents is requesting the information; and
  - (7) Include a copy of the medical bill for which the employer, insurance carrier, managed care organization or their agents is requesting the additional documentation.
- D. It is the employer, insurance carrier, managed care organization or their agents' obligation to furnish its agents with any documentation necessary for the resolution of a medical bill. The (insert state workers' compensation agency name) considers any medical billing information or documentation possessed by one entity to be simultaneously possessed by the other.



(C)

Act 203, Section 33, Workers' Compensation Workgroup Distribution List

Members:

Amy Mason	Primmer & Piper
Anthony Otis	Lobbyist
Bea Grause	Vermont Assoc. of Hospitals and Health Systems
Brian Calhoun, MD	
Catherine Z. Davis	Lake Champlain Chamber of Commerce
Claire Buckley	Kimble, Sherman and Ellis
Craig Fuller	Keller and Fuller
Dave Jillson	Practice Manager – Assoc. of Orthopaedics of VT
Don George	Blue Cross
Gerhild Bjornson	CIGNA
James Hester	Health Care Reform Commission
John Hollar	Downs Rachlin & Martin
Jonathan Wolff	Primmer & Piper
Lauren Parker	MBA Health Group
Lisa Stratton	State of Vermont
William Little	MVP
Madeleine Mongan	VMS
Mary Lacaillade	State of Vermont
Mike Bertrand	BISHCA
Mike DelTrecco	Vermont Assoc. of Hospitals and Health Systems
Stephen Monahan	Vermont Department of Labor
Nelson S. Haas	Physician
Pat Moulton Powden	Commissioner, Vermont Department of Labor
Peter Taylor	Vermont Dental Society
Carol Presley	Acadia
Rebecca Heintz	BISHCA
Rick Barrett	BISHCA
Tracey Stokes	Acadia
Paul Harrington	VMS
Bob Diubaldo	Insurance carrier
Dan Woodcock, D.C.	
Peggy Couch	Travelers
Joe Modugno	Acadia
Doreen McLaughlin	Travelers
Susan Gretkowski	NCCI

Minutes of the H.887 Workers' Compensation Study meeting held on Friday, June 20, 10:00 am – noon at the Vermont Medical Society, 134 Main Street, Montpelier, VT

Attendees: Paul Harrington, Lauren Parker, Amy Mason (phone), Claire Buckley, John Hollar, Deputy Commissioner Mike Bertrand, Mike Deltrecco, Stephen Monahan, Nelson Haas, MD, Rebecca Heintz, Rick Barrett, Lisa Stratton (phone), Carol Presley, Madeleine Mongan, Bob Diubaldo, Dan Woodcock, DC.

Paul Harrington convened the meeting at 10:00 am and after introductions the group reviewed the legislative charge of the study according to Section 33 of Act 203 (H.887). Lauren Parker and Claire Buckley presented the recommendations of common claims work group and the related draft legislation. Claire Buckley pointed out the discrepancies between the 45 day timely payment provision found in 18 VSA § 9418 and the 30 day timely payment requirement under VTDOL Rule 40.021(C). There were also discussions on the need for the following issues to be addressed: greater coordination between VTDOL and BISHCA on the enforcement of workers' compensation laws and regulations; the inclusion of health care provider in the definition of claimant for the purposes of filing a complaint with the VTDOL; updating the maximum allowable amounts for anesthesia payment; the applicability of Sections 27, 28 and 29 of Act 203 to the workers' compensation policies of casualty insurers; and, the development of guidelines for claim documentation by health professionals.

Following discussion on the recommendations of common claims work group, Paul Harrington asked each member of the study committee to comment on the draft legislation. As a result of these discussions, the group agreed to pursue the following next steps for consideration at the workgroup's next meeting on September 5th:

1. **Rule 40.000 revisions.** Stephen Monahan of the VTDOL will present recommendations on revising Rule 40.000 to address the following: standards of claim documentation by health care professionals; reconciling the 40.021(C) standard of 30 day timely payments with the 18 VSA § 9418 standard of 45 day timely payment; and updating the maximum allowable amounts for anesthesia payment (last updated in 1995).
2. **Revised definition of Claimant.** Representatives of BISHCA and the VTDOL will jointly develop a revised definition of claimant for the purposes of timely payment and enforcement that includes the injured worker, the employer, the insurance company and the health care professional. Consideration will be given to the placement of this definition in 21 VSA.
3. **Enforcement.** BISHCA and VTDOL will develop recommendations and policies to ensure better coordination and tracking of complaints between the two departments in enforcing workers' compensation laws and regulations relating to health care professionals interactions with insurance companies.
4. **Sections 27, 28 and 29 of Act 203 (H.887).** Workers' compensation policies of a casualty insurer were exempted from the provisions of Sections 27 (PAYMENT FOR HEALTH CARE SERVICES), 28 (PROCESSING CLAIMS, DOWNCODING, AND ADHERENCE TO

CODING RULES) and 29 (PRIOR AUTHORIZATION) of Act 203 (H.887). At the September 5<sup>th</sup> meeting, representatives of these carriers will report back to the committee regarding the appropriateness of their being subject to these three provisions.

5. **VTDOL bill back authority.** On page 75 of the common claims work group report, it indicates that VTDOL “was not staffed to carry out the law as the subcommittee interpreted it.” This is not the case for BISHCA, since it has the ability to recoup payments from insurance companies and other regulated entities for the cost of examinations and enforcement activities. The VTDOL will report on the desirability of being granted similar bill back authority in order to enhance its enforcement capacity..

Future meeting dates:

September 5	10:00 a.m. – noon;
October 3	10:00 a.m. – noon; and
November 14	10:00 a.m. – noon.

All meetings will take place at Vermont Medical Society’s Office, 134 Main Street, Montpelier, VT. Tel: 802 223 7898 FAX: 802 223 1201

**Minutes of the Act 203 Workers' Compensation Study meeting held on Friday, September 5, 2008, 10:00 am – noon, at the Vermont Medical Society, 134 Main Street, Montpelier, VT**

Attendees: Paul Harrington, Amy Mason, Anthony Otis, Claire Buckley, John Hollar, Deputy Commissioner Mike Bertrand, Mike Deltrecco, Stephen Monahan, Nelson Haas, MD, Rebecca Heintz, Rick Barrett, Peter Taylor, Tracey Stokes, Madeleine Mongan, Dan Woodcock, DC.

Paul Harrington convened the meeting at 10:00 am and, after introductions, he reviewed the agenda and the workgroup's meeting schedule. Consistent with Section 33 of Act 203, he indicated that he hopes to have a draft report for the workgroup to review at its November 14<sup>th</sup> meeting.

Stephen Monahan of the VTDOL and BISHCA Deputy Commissioner Mike Bertrand presented their recommendations regarding a revised definition of claimant for the purposes of timely payment and enforcement, information sharing between BISHCA and VTDOL and a model act for electronic medical billing. They indicated that they had met in July to discuss these issues and they were in agreement that: BISHCA and VTDOL would work to ensure that both departments were aware of billing complaints so that action could be taken where a pattern or practice of nonpayment or improper payment could be identified and pursued. In addition, both departments agree that references to workers' compensation medical billing should be deleted in Title 18 and addressed in the workers compensation statute found in Title 21. BISHCA and VTDOL also agree that a uniform definition of "claimant" should be provided in the statutes, and that it should mean service recipient. Where the existing statute references claimant, healthcare provider should be added. (The effect of this would be that the service recipient, the health care provider and the commissioner would all receive notice when a bill is disputed or more information is requested.)

Prior to the 9/5 meeting, Steve Monahan provided a Model Act on Electronic Medical Billing for Workers' Compensation prepared by the IAIABC that was emailed to the workgroup. According to its website, the IAIABC is an association of government agencies that administer and regulate their jurisdiction's workers' compensation acts. Along with these government entities, various private organizations involved in the delivery of workers' compensation coverage and benefits participate in the IAIABC (see <http://www.iaibc.org>). The model act includes proposed sections for medical documentation, standards for timely payment and interest, as well as communication between health care providers and patients. A drafting workgroup was formed to develop the legislation proposed by BISHCA and VTDOL consisting of Paul Harrington, Steve Monahan, Mike Bertrand, Claire Buckley, John Hollar and Mike Deltrecco. The drafting workgroup will utilize language in the IAIABC model act when appropriate.

Steve Monahan also updated the workgroup on the VTDOL's position on revising Rule 40.000 in order to reconcile the rule's 40.021(C) standard of 30 day timely payments with the 18 VSA § 9418 standard of 45 day timely payment; and updating the maximum allowable amounts for anesthesia payment (last updated in 1995). He indicated the VTDOL was committed revising Rule 40.000 to address these issues and others, such as the fee for depositions, but that it was unclear when the VTDOL would file its revisions to the rule.

On page 75 of the common claims work group report, it indicates that VTDOL “was not staffed to carry out the law as the subcommittee interpreted it.” This is not the case for BISHCA, since it has the ability to recoup payments from insurance companies and other regulated entities for the cost of examinations and enforcement activities. Steve Monahan indicated that the VTDOL has not taken a position on being granted similar bill back authority in order to enhance its enforcement capacity..

At the June 20<sup>th</sup> meeting of the workgroup it was noted that workers’ compensation policies of a casualty insurer were exempted from the provisions of Sections 27 (PAYMENT FOR HEALTH CARE SERVICES), 28 (PROCESSING CLAIMS, DOWNCODING, AND ADHERENCE TO CODING RULES) and 29 (PRIOR AUTHORIZATION) of Act 203 (H.887). John Hollar indicated that he will report to the workgroup at its October 3<sup>rd</sup> meeting on the appropriateness of casualty insurers being exempt from these three provisions.

Neil Haas, M.D., presented the findings of his report entitled: Insurance Reimbursement for Workers’ Compensation and Other Outpatient Services at North Country Hospital. In response to atypically-long delays in payment for services by workers’ compensation insurance carriers, Dr. Haas presented data from the Outpatient Billing Office of North Country Hospital (NCH) from seven practices at NCH for a 22-month period. In his draft summary and conclusions on page 4 of the report, he found that “(W)hen considering the average residence times in accounts receivable at NCH by insurance type, workers’ compensation carrier (41 days average in accounts receivable) do not compare favorably to the weighted average for time in accounts receivable for all insurance, which is 26 days. However, the lower hospital aggregate reimbursement time may be influenced by the quickness in payment of insurance carriers with larger volumes (for example, Blue Cross/Blue Shield), well-known and well-defined billing and documentation criteria (Blue Cross/Blue Shield, Medicare, Medicaid), well-defined relationships and agreements with NCH (for example, preferred provider organizations), or less contention about need and payment for services (for example, obstetrics services).”

Again on page 4 of the draft report, Dr. Haas also made the following suggestions: “(I)n order to understand if and why workers’ compensation insurance carriers are delaying payment, we must make unconfounded comparisons between provision of similar services. We must set standards for documentation so that we can determine when a claim is legitimately delayed due to documentation deficiencies. Guidelines for what determines a legitimate claim and legitimate treatment for an accepted diagnosis would be helpful.”

The workgroup expressed its appreciation to Dr. Haas for the high quality and thoroughness of his research project. He stated that he would present a revised report at a future meeting of the workgroup. Mike Deltrecco (VAHHS) and Claire Buckley (RRMC) indicated they would undertake similar research regarding delays in payment for services by workers’ compensation insurance carriers and report their findings. The workgroup also assumes that Lauren Parker (MBA) will present her findings on payment delays at the October meeting.

Steve Monahan provided a detailed overview of the number of workers’ compensation claims received by the VTDOL and he quantified the subset of claims that require either an informal or

a formal review process. Steve was asked to provide the workgroup with a narrative of the VT DOL claim review process and summary of the number of claims in each category.

Paul Harrington concluded the meeting by reviewing the workgroup's charge under Section 33 of Act 230.

There being no other business, the workgroup meeting adjourned at 11:50 am.

Future meeting dates:

October 3	10:00 a.m. – noon; and
November 14	10:00 a.m. – noon.

Dial in number: 1 (800) 377-8846. Pass code: 54096025#

All meetings will take place at Vermont Medical Society's Office, 134 Main Street, Montpelier, VT. Tel: 802 223 7898 FAX: 802 223 1201

**Minutes of the Act 203 Workers' Compensation Study meeting held on Friday, October 3, 2008, 10:00 am – noon, at the Vermont Medical Society, 134 Main Street, Montpelier, VT**

Attendees: Paul Harrington (VMS), Amy Mason (PPEC), Clare Buckley (KSE), John Hollar (DRM), Deputy Commissioner Mike Bertrand (BISHCA), Mike Deltrecco (VAHHS), Stephen Monahan (VTDOL), Nelson Haas, MD, Rebecca Heintz (BISHCA), Rick Barrett (BISHCA), Dan Woodcock, DC., Peggy Couch (Travelers), Joe Modugno (Acadia), Doreen McLaughlin (Travelers), Carol Presley (Acadia), representative of Anthony Otis

Paul Harrington convened the meeting at 10:00 am and, after introductions, he reviewed the agenda and the workgroup's meeting schedule. Consistent with Section 33 of Act 203, he indicated that he plans to have an outline of the draft report for the workgroup to review at its November 14<sup>th</sup> meeting.

The workgroup reviewed the 10/2 draft legislation developed by the drafting workgroup consisting of Paul Harrington, Steve Monahan, Mike Bertrand, Clare Buckley, John Hollar and Mike Deltrecco. Harrington indicated that the draft bill language reflected Steve Monahan and Mike Bertrands' recommendation that references to workers' compensation medical billing be deleted in Title 18 and addressed in the workers compensation statute found in Title 21. He pointed out there are three sections in the draft that closely track the provisions of 18 V.S.A. § 9418 and provisions from the IAIABC model act provided by Steve Monahan.

The first section of the draft adds definitions of "medical or health care bill" and "denied medical payment" to 21 V.S.A. § 601. The second section inserts the revised 18 V.S.A. § 9418 requirements into a new subsection 21 V.S.A. § 640(e). Throughout, the 21 V.S.A. terms "employer or insurance carrier" and "injured employee" are substituted for the 18 V.S.A. terms "health plan" and "patient" respectively. Since there is currently a lack of consensus of the time period for paying bills, the draft includes both the Rule 40.000/Model Act's 30 day standard and the 18 V.S.A. § 9418 45 day standard for timely payment. Harrington also pointed out that under new (e)(3) "Disputes regarding any medical bills under this subsection may be filed with the commissioner by the injured employee or health care provider..."

The draft's second section also includes a new subsection 21 V.S.A. § 640(f) intended to reflect more detailed document standards. The provision is based on language from the Model Act and Rule 40.000. The third section of the draft deletes the 18 V.S.A. § 9418(c) reference to workers' compensation insurance policies.

The workgroup reviewed each page of the draft and made a number of suggestions that will be reflected in future drafts. Steve Monahan agreed to draft specific penalties that the Commissioner of DOL may assess for inclusion in paragraph 640(e)(5) of the draft; Steve Monahan and Mike Bertrand agreed to draft a new paragraph 640(e)(7) on the role of BISHCA; Neal Haas, MD, agreed to provide revised language for subsection 640(f) relating to medical documentation; and, John Hollar will submit for review a new subsection 640(g) on the denial of future medical bills relating to the same injury. A new draft of the proposed legislation will be distributed for review prior to the November 14<sup>th</sup> meeting.

Steve Monahan was asked if the VTDOL had taken a position on being granted bill back authority similar to BISHCA's in order to enhance its enforcement capacity. He indicated that the issue has been raised within the department, but no decision had been made at that time.

John Hollar had been asked to report to the workgroup on the appropriateness of casualty insurers being exempt from the provisions of Sections 27 (PAYMENT FOR HEALTH CARE SERVICES), 28 (PROCESSING CLAIMS, DOWNCODING, AND ADHERENCE TO CODING RULES) and 29 (PRIOR AUTHORIZATION) of Act 203 (H.887). On his behalf, Doreen McLaughlin of Travelers spoke against applying Section 28 to casualty insurers, due to her company's desire to be able to continue down-coding medical bills (pay for a lower reimbursed procedure rather than one the billed by the health care provider for treating the injured employee). Hollar had no clients who wished to speak on the applicability of the sections 27 and 29 to casualty insurers.

Mike Deltrecco (VAHHS) presented a list of common workers compensation issues from hospital billing departments. Many of the issues were identified in the common claims workgroup and documented in the report.

Neil Haas, M.D., provided the workgroup with an updated version of his research paper on Insurance Reimbursement for Workers' Compensation and Other Outpatient Services at North County Hospital. He also discussed the findings from his presentation on The Workers' Compensation Claims/Claims of Workplace Injury and Illnesses and Other Factors, and the experiences and recommendations of Gregory Gilbert, Senior Vice President with Concentra (a company offering employment related healthcare through 321 health care centers in 40 states). The workgroup again expressed its appreciation to Dr. Haas for the high quality and thoroughness of his research.

There being no other business, the workgroup meeting adjourned at noon.

Future meeting dates:

November 14            10:00 a.m. – noon.

Dial in number: 1 (800) 377-8846. Pass code: 54096025#

All meetings will take place at Vermont Medical Society's Office, 134 Main Street, Montpelier, VT. Tel: 802 223 7898 FAX: 802 223 1201

**Minutes of the Act 203 Workers' Compensation Study meeting held on Friday, November 14, 10:00 am – noon, at the Vermont Medical Society, 134 Main Street, Montpelier, VT**

Attendees: Paul Harrington (VMS), Amy Mason (PPEC), Clare Buckley (KSE), Lucy Garland (DRM), Deputy Commissioner Mike Bertrand (BISHCA), Mike Deltrecco (VAHHS), Stephen Monahan (VTDOL), Nelson Haas, MD, Rebecca Heintz (BISHCA), Rick Barrett (BISHCA), Dan Woodcock, DC., Susan Gretkowski (NCCI), Crystal Bouquet representing Anthony Otis, Mary Lacaillade, Lauren Parker

Paul Harrington convened the meeting at 10:00 am and, after introductions, he reviewed the agenda and the minutes of the October 3<sup>rd</sup> meeting.

On a page-by-page basis, the workgroup reviewed the 11/14 draft legislation this represented the next draft following the 10/2 draft developed by the drafting workgroup consisting of Paul Harrington, Steve Monahan, Mike Bertrand, Clare Buckley, John Hollar and Mike Deltrecco.

In the first section of the 11/14 draft, DOL agreed in order to achieve consistency between workers' compensation and health insurance that the Rule 10 definition of medical necessity should be used instead of the Rule 40 definition. In the second section, DOL stated it would support changing the current 18 V.S.A. §9418 45-day timely payment standard to a 30-day standard in order to be consistent with Rule 40 and the proposed revisions to timely payment required for health insurance (note: John Hollar has indicated by e-mail that AIA opposes the proposed 30 day standard due to the complexity of worker's compensation). Proposed §640(f)(5) and §640(f)(7) were revised to track the current optional penalty language in 21 VSA §688 and there was agreement that automatic interest would be assessed, consistent with the interest provisions relating to health insurance under 18 V.S.A. §9418. There was also agreement that the draft should include a 6-month medical bill filing provision. The provision reflects BISHCA's position that would bar failure to pay medical bills, unless there is prejudice to the carrier.

There was extension discussion regarding Dr. Neil Haas' extensive research relating to work-related injury documentation standards. There was wide agreement that they represented an excellent standard of documentation for workers' compensation that would be highly suitable for educational seminars. However, the consensus of the working group was that the standards were too extensive for inclusion in the proposed legislation.

There was discussion relating to John Hollar's earlier recommendation to add a section 640(g) on the denial of future medical bills relating to the same injury. There was a general consensus that the proposed language was too broad for inclusion in the proposed legislation.

Steve Monahan recommended the inclusion of a new section relating to subrogation of medical bills between worker's compensation carriers and health insurance companies. Susan Gretkowski requested that the proposed language be shared for comment prior to finalizing the workgroup's report to the legislature (the 11/24 draft legislation was e-mailed to the workgroup on 11/25).

Finally, there was agreement that Act 203 (H.887) Sections 27 (payment for health care services), Section 28 (processing claims, down coding and adherence to coding rules) and Section 29 (prior authorization) should apply to the workers' compensation policies of a casualty insurer. (Note: John Hollar has indicated that Travelers Insurance Company is opposed to being subject to a limitation on down coding. This is consistent with Travelers' testimony opposing the proposed ban on down coding during the 10/3/08 work group meeting.)

The workgroup then reviewed the proposed below following outline of the report to the legislature, which was agreed to.

### **H.887 (Act 203) Workers' Compensation Study**

Draft Outline of Report, 11/14/08

#### **Executive Summary (2 pages):**

Legislative charge  
Problem statement  
Proposed solutions  
Unresolved issues

#### **Report (6-8 pages)**

Expanded problem statement  
Study group process  
Summary of research findings: Dr. Haas, VAHHS. IAIABC Model Act  
Summary of proposed legislation  
Summary of unresolved issues

#### **Appendix**

Text of Act 203 charge  
Recommendations from common claims committee  
Proposed legislation  
List of participants and minutes of meetings  
Research from Dr. Haas and VAHHS  
IAIABC Model Act

There being no other business, the workgroup meeting adjourned at noon.

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## **Workers Compensation Simplification Sub-Committee of the Common Claims Workgroup**

### **Summary of Findings and Recommendations**

**Findings: Workers Compensation Claims Protocols are inefficient and laws to protect the all impacted parties are ineffective**

- 1) Claims must be authorized by employer and reported to both the State and the Carrier (First Report of Injury). Law mandates that these be filed electronically but there are exceptions so many are filed on paper and there is a backlog of data entry into the system at the State.
- 2) Claims must be submitted on paper with a copy of the visit documentation – these claims are often “lost” in their paper system. At one point it was determined that of claims not paid within the 45 day time frame, over 80% were stated to be “no claim on file”.
- 3) The majority of claims are not paid or denied within the 45 day timely payment window set by 18 VSA 9418.
- 4) Claims must be followed up on via phone to the carrier of record – there is no option to track claims electronically.
- 5) The Law as written does not define the provider/physician as a party of interest. The law does not allow for claims to be transferred to the patient for lack of payment by the carrier but the provider and their loss of income is not covered in the law unless the claim is denied.
- 6) Workers Comp and Safety Division is not staffed to assist in the follow up on all unpaid claims.
- 7) Even with a law in place requiring electronic filing of FROI and timely payments, there are no incentives for the carriers to follow the rules put in place by the law.
- 8) The law states that the carrier must notify the claimant (in this case the patient) and the commissioner of labor that the claim is contested or denied.
- 9) Most physician practices and hospital billing departments have

#### **Recommendations:**

- 1) Move oversight to BISHCA who already has oversight of all other medical claims
- 2) Eliminate the double filing of FROI and expedite the requirement for electronic filing of the FROI
- 3) Initiate tracking of complaints regarding timely payment of claims
- 4) Eliminate the pattern of practice requirement or require that data be compiled by WCSD among all providers to determine if there is violation by any particular carrier
- 5) Encourage the study of other state’s implementation of electronic filing of work comp claims

## **Workers Compensation Recommendations Summary**

Of primary concern to the provider (both hospital and physician office) as well as the employees (patients) is the time and effort involved in getting payment for services rendered. Details of this situation can be found in the report submitted by the Common Claims Committee to the legislature.

To further complicate the resolution of outstanding claims, the regulations that have been defined by the VT State Legislature are not being enforced due to lack of time, staffing and priority of responsibility at the Worker's Compensation and Safety Division (WCSD) of the Department of Labor. According to WCSD their primary responsibility is to assure that employees receive the appropriate care for their work related injuries.

Our initial recommendation was to increase the staffing levels at WCSD until we were advised that there would be no increase in staffing authorized in 2008. With a job freeze at the State offices and after reviewing the staffing at WCSD, we decided to recommend that enforcement of timely payment provisions be transferred to BISHCA, where other medical claims timely payments are presently enforced. Funding for the extra responsibilities could be realized through the assessment of penalties.

Vermont law already has defined protocols for timely payment regulations. The timely payment provision in 18 V.S.A § 9418(c) reads as follows:

- 1) If the claim submitted is to a health plan that is a workers' compensation insurance policy, The health plan shall within 45 days following receipt of the claim: (A) pay or reimburse the claim; or (B) notify in writing the claimant and the commissioner of labor that the claim is contested or denied. The notice shall include specific reasons supporting the contest or denial and a description of any additional information required for the health plan to determine liability for the claim.
- 2) Disputes regarding any claims under this subsection shall be resolved pursuant to the provisions of chapters 9 and 11 of Title 21
- 3) The commissioner of labor may assess interest and penalties as provided in subsections (e) and (f) of this sections against a health plan that fails to comply with the provisions of this section or any order of the commissioner. These remedies are in addition to any other penalties available under Title 8 and chapters 9 and 11 of Title 21.

The recommendations of the sub-committee for changes to Title 18 and 21 include:

- Adopt the attached recommendation (Attachment F) for an amendment to Title 18 and 21 to include
  - 1.) Change the law to transfer enforcement portion of Timely Payment Statute over to BISHCA in consultation with DOL to enforce current requirements. Initial complaints may be made to BISHCA by DOL or other parties, including providers;
  - 2.) Require Automatic interest paid to providers for lack of timely payments in alignment with medical and disability claims
  - 3.) Authorize the DOL to track carrier protocols for claims receipt, claims processing and claims paid, including an online claims status review option for providers;
  - 4.) Enable the DOL to have bill back authority for costs incurred in investigations of the WC carriers;
  - 5.) Allocate that penalties assessed against workers' compensation carriers be deposited into a DOL administration fund to pay for tracking and enforcement activities within the division.

(D)(b)

(D)(b)



VERMONT ASSOCIATION OF  
HOSPITALS AND HEALTH SYSTEMS

Here is a list of common workers compensation issues. Most of this was captured by the workers compensation subgroup of the common claims workgroup and is documented in that report.

**Overall issues:**

1. First report of injury is not electronic or timely.
2. All workers compensation billing requires a medical record to be sent with it.
3. No one will take an electronic claim for workers compensation, it is all paper.
4. There is no electronic ability to check on claim status with payers.
5. The carriers seem to lose our medical records often and then deny the bill which then needs to be appealed.
6. Department of Labor does not have the resources to help hospitals with difficult carriers who are not paying claims timely. There should be an interest penalty.
7. Some carriers are denying line items and calling them inclusive.
8. Workers compensation A/R is higher than other lines of third party payment because of all of the above.

**Specific Issues:**

**Corvel and Bunch & Associates:** They deny a lot of the supplies stating they are inclusive to another charge and refuse to reprocess.

**VT Department of Labor:** We've sent about 10 or 15 claims down for review and have yet to receive a response. The oldest we have outstanding for this is from February.

**Liberty Mutual, Peerless and Wausau:** Denied bills for lack of medical records, which FAHC sends with each and every bill. When this happens we have to appeal it which can take 45-60 days. That on top of the 30 days it takes them just to determine they have lost the medical records brings us out 90 days at least.

**Lack of authorization:** Charging off the claim for this is a rare occurrence. NY W/C is simple anything over \$1,000.00 needs to be authorized, so we make sure that happens (the burden is on the hospital). We have not seen anything in the VT State Fee Schedule about when they can deny a bill for lack of authorization. Should everything be authorized or just certain procedures? I think it varies among not just insurances, but also adjusters w/ in each company.

**Adjusters:** Certain insurance companies are impossible to reach an adjuster for. We leave messages on a regular basis and they don't return the phone call. Our perception is that all of

the carriers, except for the local companies (CCMSI, VSBIT, Acadia, Cardinal Comp) have an adjuster or 2 that will not call back. This makes it difficult when we have an issue getting a bill paid. Also there are many adjusters who do not understand the process of processing a medical bill and how to pay it per the fee schedule. We're supposed to contact them with any issues regarding payments, but how are they supposed to help us when they don't understand it themselves?

**Independent Medical Examinations:** When a patient is scheduled to have an IME the adjuster will not authorize any payments until it is completed. This takes a lot of time because usually the appointment is a month or 2 away. They aren't necessarily controverted claims and they aren't denying the bills. The bills just sit pending until the IME is performed and the doctor gets the results back to the adjuster. This whole process takes at least 2-3 months. A lot of patients don't show up for their first appointment so then another one is rescheduled. There is nothing we can do on our end, but simply wait.

**Invoices:** Requests for our invoices for surgical supplies. These are still requested by some carriers, but mostly for implants.

**DMEPOS** (Durable Medical Equipment, prosthetics, orthotics and supplies) - VT DOL Rule 40 states that "Individual invoices are not required, but documentation allowing a reasonable determination of what the provider paid for the DMEPOS must be submitted." Most WC carriers require a copy of the invoice for DME (crutches, slings, knee immobilizer) before they will pay even though invoices are not required by the rule. There are hundreds of different DMEPOS items and finding an invoice that goes with the particular item on the bill is incredibly time consuming. There is no other documentation that the hospital has that is acceptable to the carrier. If there was another way to substantiate hospital DMEPOS costs or if a different payment method for DMEPOS could be developed it would save hospitals a lot of administrative time and make the payment for these claims more timely.

(D)(C)

(D)(C)

**CRAIG E. GOLDBERG, D.O.**  
**PO BOX 2388**  
**BRATTLEBORO, VERMONT 05303**  
**802-254-4545 Phone ~ 802-254-0079 Fax**

4 April 2008

Virginia Milkey, State Representative  
**State House**  
115 State Street  
Montpelier, Vermont 05633-5301

Dear Ms. Milkey:

We appreciate this opportunity to express our concerns about the way in which Workers' Compensation carriers process claims in behalf of our patients. The reasons for our dissatisfaction are as follows:

- 1.) Claims are not processed in a timely manner. Currently we have outstanding claims with one carrier that date back to August of 2007.
- 2.) Claims are arbitrarily denied with no "medical explanation" for the denial. Probably one of the most aggravating aspects of this problem is to deal with claims adjustors who have no medical training or background and they are allowed to determine if benefits are payable. To spend hours writing and researching information to defend the osteopathic profession and its effectiveness in treating traumatic injuries is absurd. The appeals process is complicated and information about whom you need to contact is usually vague; the ability to reach "the right person" is made practically impossible through ill-defined office locations and no "800 numbers." These are all tactics to discourage doctors and office staff from pursuing payment of claims.
- 3.) Coding and billing procedures for osteopathic medicine always come under fire by workers' compensation carriers. This is a way for these insurance companies to delay payment without having to answer to anyone; no other insurance companies including Medicare and Medicaid question the legitimacy of our use of CPT procedure codes and ICD-9 codes.

This office has serviced patients with work injuries since 1993 and it has now been almost fifteen years that this problem has existed and it continues to be tolerated by Vermont Legislature and the Vermont Department of Labor. It is time that these problems were addressed and resolved. It is unfair to physicians and patients to allow this kind of abuse to continue indefinitely. Please use your authority to take action in our behalf. Your kind consideration of this urgent matter is very much appreciated.

Yours sincerely,

Craig E. Goldberg, D.O.

CEG:fc



(D) (d)

(D) (d)

**April 8, 2008**  
**Worker's Compensation Testimony**  
**Kathy Peterson, Director Patient Accounting**  
**Rutland Regional Medical Center**  
**160 Allen Street, Rutland, VT 05701**  
**802-747-3951 kpeterso@rrmc.org**

- Less than 50% of claims pay within 45 days
- Process very labor intensive
  - Must send medical records—when sent they still request—issue at all facilities
- Don't follow rules established by Rule 40
  - i.e. they ask for invoices when not supposed to on non-DME items. Big issue at all facilities
  - They don't pay according to Rule 40—pay arbitrary amounts and have to follow up and fight for the rest.
- They farm out accounts to repricing companies—give examples

Workers comp is 1% of our gross revenue and I have to dedicate one full time person to collecting these accounts due to the labor intensive process, rules not being enforced and claims not being paid. In comparison Medicare is 48.5% of our gross revenue.

Have one full time person working workers comp – currently 1168 accounts. 513 or 44% are over 180 days old.

Have 3 full time people working outpatient Medicare – currently 8503 accounts or 2834 accounts per biller and 773 accounts or 9% are over 180 days old.

Have 2 full time people working outpatient Blue Cross – currently 3229 accounts or 1614 per biller and 33 accounts or 1% are over 180 days old.



## **Insurance Reimbursement for Workers' Compensation and Other Outpatient Services at North Country Hospital**

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On June 20, 2008, the Vermont Medical Society organized a meeting of a multidisciplinary study group to address workers' compensation insurance issues. One concern was the time it took workers' compensation insurance carriers to reimburse providers for services. Loren Parker presenting her experiences from data covering billing from two practices for a three-month period, and was concerned that reimbursement times were atypically long. To expand out understanding of payment time, I undertook gathering data from all North Country Hospital (NCH) outpatient clinics where patients treated under the workers' compensation system. Below, are data from the NCH Outpatient Billing Office for a 22-month period.

### **Structure of and Approach to Postings in NCH Outpatient Clinic Accounts.**

NCH has seven outpatient clinics staffed by practitioners who regularly see patients with workers' compensation claims and that regularly bill workers' compensation insurance carriers for their services. They are listed in the right hand column of Table 1. Additionally, NCH has outpatient services in obstetrics and gynecology, oncology, sleep medicine, psychiatry, and radiology, in all of which but radiology, few workers' compensation claimants are seen. Billing for outpatient and inpatient services are kept separately. The accounts for radiology and psychiatry billing are not grouped with the outpatient clinic accounts.

### **Handling of Bills from NCH Clinics.**

Aspects of the practice billing include:

- charges for services are transmitted, in most cases with documentation (progress notes, study reports), to the NCH billing office by each practice, usually on the day of service, but some practices may transmitted charges as infrequently as twice weekly according to availability of administrative personnel;
- billing-to-payment time, measured in days (accounts receivable days, or AR days) begins with the posting of the bill for services;
- for most practices, charges are submitted to third party payers from the Billing Office within a day of being received, but documentation may not be complete when the bill is sent;
- with one practice (neurology), billing requisitions are sent to the practice from the billing office to be sent from the practice after documentation is included by administrative personnel at the practice;
- transmission of complete documentation may be delayed by
  - awaiting completion of notes by practitioners,
  - awaiting transcription, or
  - preferences of practitioner or practice manager to send documentation directly.

**Debits (Increases ) to Accounts Receivable.**

Accounts receivable is increased when charges are posted.

**Credits to (Decrease in) Accounts Receivable.**

Accounts receivable is reduced by:

- receipt of payment;
- transfer of charges for services to another type of carrier (for example, if a workers' compensation claim is denied, the denial is accepted by the claimant, and their personal health insurance is billed subsequently);
- denial of payment by a third party payer without successful petition; or
- failure of a patient to pay their portion of charges.

Charges will remain in accounts receivable while denials are disputed without consideration of the legitimacy of the denial or the likelihood that a claimant will prevail in their petition.

**Average Number of Days in Accounts Receivable.**

The average number of days charges reside in accounts receivable is computed as follows.

$$\text{Days in Accounts Receivable} = \frac{\text{Value of Services Billed for Period}}{(\text{Value of Average Daily Services in Period}/\text{Days in Period})}$$

Table 1 shows the average number of days charges for services at NCH outpatient practices reside in accounts receivable, with the third column showing figures for October 1, 2006 to July 31, 2008; the fourth column showing figures for October 1, 2006 to September 30, 2007 (fiscal year 2007); and the fifth column showing figures for October 1, 2007 to July 31, 2008 (figures compiled to date for fiscal year 2008).

The seven clinics listed in Table 1 account for almost 100% of outpatient workers' compensation bills at NCH. The occupational medicine clinic bills 48% of NCH workers' compensation outpatient bills, with the remaining six clinics accounting for almost all of the remaining 52%.

With the exception of the occupational medicine clinic, the portion billed for most services by NCH practices is a minor portion of the total services billed. The occupational medicine clinic bills approximately 60% of its services to workers' compensation insurance carriers, and has one of the shorter receipt times for accounts receivable bills of the seven clinics in Table 1.

The variability in billing among clinics and in each clinic from year to year can be substantial, as demonstrated in Table 2. The most variability for a clinic between fiscal years 2007 and 2008 was nearly 40 percent. However, the aggregate for all the clinics included in Table 2 is only 2%, showing good hospital-wide consistency between fiscal years 2007 and 2008.

Practice	Location	Days in Accounts Receivable All Insurance		
		2007	2008	2007 and 2008
Anesthesiology-Pain Medicine	Newport	44	48	46
Family Medicine	Barton	57	39	48
Family Medicine	Newport	40	39	40
General Internal Medicine	Newport	40	36	38
Neurology	Newport	39	42	41
Occupational Medicine	Newport	38	41	39
Orthopedics	Newport	56	47	51
<b>Total</b>		<b>43</b>	<b>42</b>	<b>43</b>

**Table 1. Accounts Receivable for Fiscal Years 2007 and 2008 by Practice.** Shown is the average number of days charges are in accounts receivable for fiscal year 2007 and for fiscal year 2008 from October 2007 to July 2008 (670 days) for North Country Hospital outpatient practices that see workers' compensation claimants on a regular basis. Calculations include all types of insurance.

Practice	Days in Accounts Receivable - All Insurance			Variability among Years 2007 and 2008 (%)
	2007	2008	2007 and 2008	<u>Absolute Value (2008-2007)</u> 2007 and 2008
Anesthesiology-Pain Medicine	44	48	46	9%
Family Medicine (B)	57	39	48	38%
Family Medicine (N)	40	39	40	3%
General Internal Medicine	40	36	38	11%
Neurology	39	42	41	7%
Occupational Medicine	38	41	39	8%
Orthopedics	56	47	51	18%
<b>Total</b>	<b>43</b>	<b>42</b>	<b>43</b>	<b>2%</b>
<b>Standard Deviation (days)</b>	<b>8.2</b>	<b>4.4</b>	<b>5.0</b>	
<b>Standard Deviation (%)</b>	<b>19</b>	<b>10</b>	<b>12</b>	

**Table 2. Variability in Accounts Receivable Days for Fiscal Years 2007 and 2008 by Practice.** Shown in the right hand column is the percent difference in average number of days charges reside in accounts receivable for each practice. Shown in the bottom row is the standard deviation among the seven practices included. The data are for fiscal year 2007 and for fiscal year 2008 from October 2007 to July 2008 and the variability. Calculations include all types of insurance.

Table 3 shows the days charges reside in accounts receivable by type of insurance. The range of time the average charge resides in accounts receivable is from 13 days from for bills to Medicaid for rural health care services to 75 for bills to non-workers' compensation commercial insurance carriers.

**Denials.**

Chris Fortin, the NCH Outpatient Billing Office Manager, felt that workers' compensation insurance carriers were no more disposed to deny claims than other insurance carriers.

Insurance Type	Portion of Total Services (%)	Days in Accounts Receivable – All Insurance
Blue Cross/Blue Shield	18	22
Champus-Tricare	1	54
Commercial – HMO/PPO	16	24
Commercial	2	75
Medicaid – non RHC	9	29
Medicaid –RHC <sup>1</sup>	10	13
Medicaid –RHC <sup>2</sup>	3	13
Medicare – non RHC	18	35
Medicare – RHC	13	23
Workers' Compensation	2	41
<b>Total</b>	<b>92</b>	<b>26</b>

**Table 3. Accounts Receivable for Fiscal Year 2008 by Insurance Type.** Shown is the average number of days charges are in accounts receivable for fiscal year 2007 and for fiscal year 2008 from October 2007 to July 2008 (670 days) for North Country Hospital outpatient practices that see workers' compensation claimants on a regular basis. Calculations include all types of insurance.

HMO = health maintenance organizations;  
 PPO = preferred provider organizations;  
 RHC = rural health care  
 1 – non-obstetrics services  
 2 – obstetrics services

**Notes.**

Ms. Fortin's impression was that individual workers' compensation insurance carriers demonstrated a great deal of variability in the promptness with which they pay bills.

**Summary and Conclusions.**

The average residence time in accounts receivable for all insurance bills at NCH is approximately 42 days when considering NCH outpatient practices where workers' compensation claimants are seen. Among those practices, the occupational medicine clinic, which bills workers' compensation insurance carriers for a large portion of its services, has an average residence time in accounts receivable of 39 days. The remainder of NCH outpatient practices where workers' compensation claimants are seen bill a small portion of their services to workers' compensation carriers. Based on this comparison, workers' compensation carriers do not demonstrate a higher propensity to delay payment, or other factors in clinic billing must offset workers' compensation carriers propensity to delay payment.

There is variability in accounts receivable time among practices. There may be substantial temporal variability in accounts receivable time. Factors that can account for variability in accounts receivable days include the:

- relationship and nature of arrangements between the clinic or hospital and the insurance carrier;
- integrity of the claim;
- quality of the documentation;
- completeness of the documentation;
- timeliness of completion of documentation;
- rapidity with which
  - claims are accepted or denied by the payer,
  - claim denials that are petitioned are handled administratively and legally, and
  - insurance carriers send payment in the case of legitimate and/or accepted claims;
- inclusion of treatment unrelated to the accepted claim; and
- presence of confounding factors (such as whether the claimant is adherent to return to work and treatment plans, the nature of the diagnoses, and the nature of the services rendered).

When considering the average residence times in accounts receivable at NCH by insurance type, workers' compensation carrier (41 days average in accounts receivable) do not compare favorably to the weighted average for time in accounts receivable for all insurance, which is 26 days. However, the lower hospital-aggregate reimbursement time may be influenced by the quickness in payment of insurance carriers with larger volumes (for example, Blue Cross/Blue Shield), well-known and well-defined billing and documentation criteria (Blue Cross/Blue Shield, Medicare, Medicaid), well-defined relationships and agreements with NCH (for example, preferred provider organizations), or less contention about need and payment for services (for example, obstetrics services).

### **Suggestions.**

In order to understand if and why workers' compensation insurance carriers are delaying payment, we must make unconfounded comparisons between provision of similar services.

We must set standards for documentation so that we can determine when a claim is legitimately delayed due to documentation deficiencies. Guidelines for what determines a legitimate claim and legitimate treatment for an accepted diagnosis would be helpful.

Evaluation of response time from the carrier, denial rates, and reasons for denial may direct where us to look for reasons for payment delays, inappropriate billing of the workers' compensation carriers, or inappropriate administrative delays by the carriers.

### **Acknowledgements.**

I thank Christine Fortin, the NCH Outpatient Billing Office Manager and Melissa Gallup, the NCH Occupational Medicine Clinic manager for gathering data and for their feedback.

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**Experiences and Recommendations of Gregory Gilbert,  
Senior Vice President of Reimbursement and Governmental Affairs with Concentra  
for Expediting Insurance Reimbursement for Workers' Compensation Services**

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**September 17, 2008 conversation with Greg Gilbert, of Concentra.**

I had a conversation on Wednesday, September 17, 2008 with Greg Gilbert, Senior Vice President of Reimbursement and Governmental Affairs of Concentra about his experiences with workers' compensation billing in Vermont. Mr. Gilbert was sent a survey and a copy of the report "Insurance Reimbursement for Workers' Compensation and Other Outpatient Services at North Country Hospital." The report and survey were sent to Mr. Gilbert before September 17; and were submitted to the Vermont Medical Society (VMS) multidisciplinary working group.

**Conversation with Mr. Gilbert.**

Concentra is a nationwide company that offers employment-related healthcare through 321 health care centers in 40 states. Mr. Gilbert explained that a core Concentra service is delivery of care to workers' compensation claimants. A large part of Concentra's revenue is derived from those services. Concentra has clinics in South Burlington and Berlin, Vermont. The clinics in Vermont are part of Concentra's Northeast Regional division with its headquarters in Rhode Island.

**Payment Delays – Accounts Receivable Days.**

Mr. Gilbert pointed out that accounts receivable (AR) days are customarily reported for three-month periods; that workers' compensation claims vary with time, usually with fewer claims made at the beginning and end of the calendar year compared to the middle of the calendar year; and that AR days are usually computed using the balance in the AR account at the end of a period. When considering AR days, he finds consideration of total AR days and the proportion of claims with AR days over 120 helpful.

**Accounts Receivable Days in Concentra's New England Clinics.**

Mr. Gilbert's experiences with Concentra's AR is that the New England region has some of the lower AR days nationally, with AR days "in the low 40s." (He later specified in an email communications that AR days for the two Concentra centers in Vermont was 41 as of August 31, 2008, and AR greater than 120 days old as a percent of total accounts receivable as 5.5 as of August 31, 2008. He described the more problematic states as having AR days "in the 80s" or higher.

**Issues with Billing.**

Mr. Gilbert explained that Concentra has an efficient billing system and well-formulated approach to their patients, allowing them efficiencies of experience and scale that may not be realized by other organizations or practitioners who do not have a focus on and more experience with workers' compensation issues, and are not as large.

He reported that some of the most significant delays in Concentra's receipts from workers' compensation insurance carriers (WCIC) occur early in the claim and attributable to insurance companies refusing to pay for health care services until the first report of injury (FRI) is received from the insured employer. He recounted that if the employer has not sent the FRI to the WCIC, the WCIC usually delays acceptance of the claim and payment for services until the WCIC receives the FRI. Significant delays may occur because of the failure of transmission of the FRI from employer to WCIC as (1) many employers will not meet their responsibility to file the FRI in a timely fashion and (2) the WCIC may not take any action, including paying the bill or contacting the employer to expedite the claim if they have no FRI. He described a convenient indifference by the WCIC when a FRI is not received from the employer of a claimant.

As the WCIC is required in most or all states to pay a claim for services within a specified amount of time, the WCIC usually chooses to count that time, in the case of an initial claim, when they have the completed paperwork, including the FRI, and not from the time when they receive the bill for services and supporting documentation from the health care provider. Thus, WCICs may report their payment times in the teens of days when providers may have substantially-longer AR days.

The additional issue of what constitutes complete documentation arose here. He felt a clear understanding of what comprises complete documentation or a "complete billing package" may be helpful.

Mr. Gilbert said that Texas included in its workers' compensation rule a requirement that WCICs start counting AR days in an initial claim from the day they receive a bill, and not from the time they receive the FRI from the employer. He felt this rule had motivated WCICs to contact the employers of claimants and start investigations of claims in a timely fashion, even when FRIs have not been received. The Texas rule is contained in Appendix A, below.

He intends to complete the survey provided to him and send it to the VMS workers' compensation working group.

#### **Electronic Billing.**

Mr. Gilbert said that his experiences with electronic billing were that it was helpful in expediting claims and payment for services. He recounted that California and Texas have workers' compensation rules that require WCICs to accept electronic bills. California has mandatory submission and receipt of electronic bills; and Texas has optional submission and mandatory receipt of electronic bills. He pointed out that mandatory submission may be a barrier to providers, particularly those who do not treat workers' compensation claimants as a significant part of practice, as a discouragement to providing care to workers' compensation claimants. Mr. Gilbert felt the Texas approach of optional submission by providers and mandatory receipt by WCICs of electronic bills was optimal.

We discussed the International Association of Industrial Accident Boards and Commissions (IAIABC) model bill for electronic billing. Mr. Gilbert was familiar with and active in the IAIABC, but we did not discuss his recommendations about the IAIABC model bill for electronic billing in detail.

#### **Guidelines.**

We discussed the use of guidelines in the management of workers' compensation claims. The *Occupational Medicine Practice Guidelines* from the American College of Occupational and Environmental Medicine (ACOEM) are used in California and the *Official Disability Guidelines* from the Work Loss Data Institute (WLDI) are used in Texas. Both states recognized their respective guidelines' specifications as presumptively correct in management of workers' compensation claims, with deviations from the guidelines' specifications requiring explanation from the provider who deviates from them as to why he/she deviated. California implemented ACOEM *Guidelines* in 2004 and more recently.

Mr. Gilbert felt the WCICs misused the requirement to follow the guidelines initially after the rule was passed in California, leading to arbitrary denials; but the rules in California were subsequently moderated mitigating many of the initial difficulties. Texas implemented a more-nuanced rule that had a better initial implementation. He felt both Texas and California realized a decrease in claims after implementation of guidelines, and that some of the disputes that lead to longer denial without efficient resolution were eliminated. He believed implementation of guidelines did not have a large impact on AR days.

### Suggestions.

The following was suggested by Mr. Gilbert:

1. A requirement in the state workers' compensation rules for WCICs to accept electronic billing would be helpful. However, he felt that the use of electronic billing by all provider would be counterproductive, particularly in rural areas, as it may discourage small providers from offering services to workers' compensation claimants.
2. A rule requiring, in the case of an initial claim, the WCIC to count AR days from the day of receipt of the bill for services from the provider would be helpful. This would reduce the delays caused by WCICs waiting for FRIs from their employer/policy-holders without taking other action.
3. It would be helpful to define a complete billing package. Thus, there would be a clear understanding for the WCICs and providers as to documentation that would be necessary.
4. Rules for the use of guidelines should be formulated in such a way as to prevent arbitrary denials when the guidelines are not followed.
5. When comparing the AR days reported by providers or their agents, we should take into account the periods chosen. We should compare AR days computed in the same manner, for example, using three month periods and the end-period AR balance. We should also account for how annual variations in workers' compensation services may affect AR days when we consider shorter accounting periods.

Additionally, my recommendations include.

- Gathering additional information about proportions of claims delayed over 120 days may give insight into the proportions of contentious issues and contentious claims in the workers' compensation system.
- Specifying a uniform method of counting billing time or AR days would be helpful. For example, WCICs should start counting billing delays from the receipt of a complete billing package, and providers should start counting billing delays from the day the billing package is completed. This will make comparisons more valid and help identify the source of delays.
- A report of the experiences with electronic billing from the States of California and Texas may be helpful for use so that we may benefit from the experiences of the California Department of Industrial Relations and the Texas Workers' Compensation Commission. We may be able to identify problems with and improve implementation of an electronic billing system in Vermont, and have a better idea of the effects, including the degree to which billing delays may be reduced.
- Additionally, obtaining reports from California and Texas about their experiences with guidelines and Texas' experiences with implementation of the bill requiring WCICs to take action upon receipts of bills for workers' compensation services would be helpful.

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### Appendix A – Texas Workers' Compensation Regulation for Insurance Carrier Responsiveness.

- (a) Except as provided in subsections (b) and (c) of this section, written notice of injury, as used in the Texas Workers' Compensation Act, §409.021, consists of the insurance carrier's earliest receipt of:
  - (1) the Employer's First Report of Injury as described in §120.2 of this title (relating to Employer's First Report of Injury);
  - (2) the notification provided by the Commission under subsection (e) of this section; or
  - (3) if no Employer's First Report of Injury has been filed, *any other communication regardless of source, which fairly informs the carrier of the name of the injured employee, the identity of the employer, the approximate date of the injury and information which asserts the injury is work related.*
- (b) Written notice of injury for a certified self-insurer is received on the date the qualified claims servicing contractor designated by the self-insurer under Texas Labor Code §407.061(c) receives the notice.
- (c) Written notice of injury for a political subdivision that self-insures under Texas Labor Code §504.011, either individually or through an interlocal agreement with other political subdivisions, is received on the date the intergovernmental risk pool or other entity responsible for administering the claim receives the notice.
- (d) The carrier shall immediately create a written record on paper or in an electronic format of the earliest notice of injury as defined in subsection (a) of this section that is not received in writing. The date of receipt of a written notice of injury shall be deemed to be the earliest date the carrier receives the information identified in subsections (a)(1), (2), or (3) of this

Experiences and Recommendations of Gregory Gilbert of Concentra  
for Expediting Insurance Reimbursement for Workers' Compensation Services

section. Upon request of the Commission, a carrier shall provide an affidavit indicating the receipt or non-receipt of a notice of injury received and the receipt date.

- (e) The Commission shall furnish written notification to the carrier when a source other than the carrier reports:
- (1) an injury that may cause the employee eight days or more of disability or has resulted in an impairment;
  - (2) a death; or
  - (3) an occupational disease.
- (f) If a carrier is notified of an injury for which it has not received an Employer's First Report of Injury, from the employer, the carrier shall contact the employer regarding the injury within seven days of notification.
- (g) Subsections (b) and (c) of this section apply only to compensable injuries with a date of injury on or after September 1, 2003.

Source Note: The provisions of this §124.1 adopted to be effective August 29, 1999, 24 TexReg 6503; amended to be effective March 14, 2004, 29 TexReg 2321

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**Appendix B – Qualifications and Biographical Sketch of Mr. Gilbert.**



Gregory M. Gilbert, CPAM

Senior Vice President,

Reimbursement and Governmental Affairs

Greg Gilbert joined Concentra in 1994, provides management and operational direction for our national network of occupational health centers. He is also actively involved in legislative initiatives in various states concerning workers' compensation laws and policies. He has participated in numerous public presentations at workers' compensation public hearings with respect to proposed changes to laws, policies, and fee structures.

Mr. Gilbert has served on several state committees for workers' compensation initiatives:

- Texas Health Care Network Advisory Committee, tasked with determining the feasibility of regional workers' compensation networks in Texas; appointed by the Texas governor, 2001
- Maryland Workers' Compensation Fee Guide Revision Committee, tasked with developing a new medical fee schedule for Maryland; appointed by the Maryland Workers' Compensation Commissioner, 2001
- Georgia Medical Advisory Committee, tasked with developing a new workers' compensation fee schedule process; appointed by the Georgia Workers' Compensation Executive Director, 2003
- Nevada Fee Development Committee, member

Mr. Gilbert earned his BS degree in health professions from Southwest Texas State University and his MBA from the University of Dallas. He is a certified patient account manager (CPAM) through the American Association of health care Administrative Management (AAHAM).

Concentra Leadership. <http://www.concentra.com/About-Concentra/Leadership/Gilbert/>. Accessed September 19, 2008.

## Determining Causation in Claims of Work-Related Disease and Injury

Nelson S. Haas.

Occupational health practitioners routinely face employees' claims of work-related discomfort, illness, and disability. The claims often come in conjunction with notifications of diagnoses and conclusions about causation, often offered by primary care providers or medical and surgical sub-specialists who lack training, knowledge, and experience in determination of causation and work-place assessment.

Deciding whether or not a job or a work area is likely to cause or contribute to disease should be a considered when an employer allocates resources, and an employer and the employer's representative choose to accept or deny a workers' compensation claim. The safety or hazardousness of a piece of equipment or work area may compel an employer to replace a piece of equipment or revise a work area, to rotate personnel to lessen exposure, to hire more personnel to distribute workload more widely, or to assign work to a subcontractor.

In order to address the issue of causation crucial to occupational health providers, this article contains a review of the clinical approach used to determine causation as outlined by the National Institutes of Occupational Health and Safety (NIOSH) in 1979 in "A Guide to the Work-Relatedness of Disease," edited by Kusnetz and Hutchinson [1] that outlines a six-step process as follows:

- "1. consideration of evidence of disease,
- "2. consideration of epidemiologic data,
- "3. consideration of evidence of exposure,
- "4. consideration of validity of testimony,
- "5. consideration of other relevant factors, and
- "6. evaluation and conclusion."

### Diagnosis.

When considering evidence of disease, a thorough history and physical examination should be performed and the findings applied to acceptable criteria to form a list of likely diagnoses (differential diagnosis) [DeGowin and DeGowin1994]. A cursory evaluation can lead to missed diagnoses, inappropriate treatment, and inaccurate attribution of cause. For example, if a person who has a job that demands prolonged overhead work has shoulder pain that is due to idiopathic adhesive capsulitis, or crystalline or infectious arthropathy only underwent and examination to elicit the presence of an impingement syndrome, they may erroneously be diagnosed with a shoulder impingement syndrome and have it designated as a problem that was caused by work, even though the etiologies of the former three are likely to have nothing to do with activities or occupation and may lead to in appropriate treatment.

Diagnoses should be assigned in accordance with diagnostic guidelines or reliable reference sources [ACOEM Guidelines 1998]. There is no one diagnostic standard. However, many professional societies publish lists of diagnoses and diagnostic criteria.

For example, for assigning diagnoses to persons with complaints of musculoskeletal discomfort, the American College of Occupational and Environmental Medicine (ACOEM) has diagnostic standards in *Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers*, the American Academy of Orthopaedic Surgeons published *Essential of Musculoskeletal Care* [6] or the Arthritis Foundation published *Primer on the Rheumatic Diseases* [7]. Many of these references also contain lists of differential diagnoses for a particular region or category of complaint.

### **The Role of the Occupational Health Nurse.**

The occupational health nurse should obtain copies of the records to ensure that an adequate evaluation was performed, including a description of the timing and onset of the discomfort, the pattern of discomfort, aggravating and alleviating factors, and associated symptoms.

As documentation for an initial evaluation, an examiner should record a history of present illness, an occupational history, a physical examination, and a diagnosis or differential diagnosis. When no diagnosis is assigned, an explanation for the absence should present. If the aforementioned is not regularly present in the documentation, the evaluator should be asked to include more information in the assessment. If asked, the examiner should be able to cite the diagnostic criteria used, preferably with a reference to an authoritative book or professional society guideline. An accurate, supportable diagnosis may be important if subsequent to the initial claim, the diagnosis is changed or expanded. Good reasons for changes in or expansion of diagnosis should be offered by a clinician when they occur.

In subsequent evaluations, the evaluator should reproduce key elements of the examination, particularly positive examination maneuvers, and use them as part of the data in judging progress.

When a nurse encounters a treating clinician that assigns diagnoses without an adequate evaluation, makes causation determinations without having documented an adequate history and physical examination, or who cannot support their diagnoses or causation determination determinations with citations from medical literature, other clinicians should be considered.

### **Method to Assess Causation.**

The NIOSH approach determination of causation [Kusnetz and Hutchinson 1979] has been recognized and embraced in the *Practice Guidelines* of the American College of Occupational and Environmental Medicine (ACOEM) [2, page 60 and 71] and in a publication of the American Academy of Orthopaedic Surgeons [3, page 67].

ACOEM further specified that “[u]nless the causal factor had an immediate and visible effect on the patient, imputing causation to a work factor (whether it be an acute event or an exposure, organizational or psychological conditions, or a chronic or recurrent exposure) requires that there be reasonable epidemiologic evidence for the association. The coexistence of the exposure and the effects is necessary but not sufficient.” In other words, to designate reliably an exposure as a cause of a health condition, other than in the

case of acute trauma with immediate and visible injury, the occupational health professional must reference epidemiologic evidence.

There are multiple reasons for depending on diagnosis, exposure, and epidemiological data rather than an employee's or employer's representation of work-relatedness that usually depends heavily on temporal associations.

1. Chance occurrences are may be interpreted as cause and effect.
2. A lack of tolerance for an activity that provokes symptoms may be mistaken for the activity causing illness.
3. Witting and unwitting self-interest can influence a person's perception and representation of events.
4. People look to assign or avoid blame, whether in anger, to avoid guilt, or to look for explanation; thus may look for an obvious or proximate cause whether or not an association exists.

#### **Epidemiology, Statistical Inference, and the Use of Epidemiologic Criteria.**

Epidemiology is "the study of the distribution and determinants of disease and injuries in human populations," and is concerned with disease in groups of people and the personal and group characteristics and exposure that are associated with the occurrence or presence of disease or injuries [Mausner and Kramer 1985].

#### **Association, and Cause and Effect.**

Analysis of epidemiological data from different groups with demonstration of statistically significant differences between groups of healthy and diseased, and exposed and unexposed persons may show an association between exposure and disease, but does not in itself show that the association represents a cause-and-effect relationship. Other information must supplement statistical analysis to bolster claims of cause and effect.

#### **Hill's Criteria for Determination of Causation.**

The following criteria for assessing a cause-effect relationship from epidemiologic evidence have been specified in similar forms by the United States Surgeon General [1964], Austin Bradford Hill [1965], and the ACOEM *Guidelines* []; are applied by epidemiologists, public health officials, and clinical scientists to studies of human populations; and are often referred to as "Hill's Criteria."

- The exposure and disease under consideration, to guard against the association being due simply to chance, should have a statistically significant association which, by scientific convention, should be at or above the 95 percent confidence level.
- The association should be strong. (The issue of what constitutes adequate strength to suffice as proof of association in workers' compensation claims will be discussed further below.)
- The association should be specific. Multiple potentially causative exposures or factors should be investigated and tested for association, and the non-occupational factors for the health condition should be relatively weak, if present at all, when compared to occupational factors.
- The exposure must precede the health condition.
- The association between disease and exposure should be consistent. That is, to be sure of the association, multiple studies comparing putative cause and effect should be available and support the same association. Additionally, it is helpful when

studies performed under different sets of circumstances (for example, at different industries with similar exposures, different at locations or companies, or with different populations) support the association.

- There should be a graded relationship between the intensity of the exposure and disease, also known as a dose-response relationship or predictive performance of the association.
- The association should be logically consistent with biologic or statistical evidence as to how disorder could develop. This is termed the *coherence of the association*.

### **Strength of Association Necessary to Satisfy Customary Workers' Compensation Criteria.**

When applying scientific data, the circumstances in which the data are to be applied must be considered. In most states, including Vermont, an "occupational disease" is a disease that results from or is caused by conditions characteristic of and peculiar to a particular trade, occupation, process, or employment, and to which an employee is not ordinarily subjected or exposed outside or away from the employment; and arises out of and in the course of employment [10]. Put in other ways, if a condition is an occupational disease, it should have been a "direct and natural consequence" of work, or would not have occurred "but for" employment [11].

The usual level of proof to determine that a health condition was caused by an exposure at the workplace is a preponderance, or more than 50 percent, of the evidence should support the connection between an occupational exposure and the disease.

### **Epidemiologic Standard for Determining Adequate Strength to Meet or Exceed a Preponderance of the Evidence.**

In epidemiological studies, populations are observed in attempts to associate workplace exposures to the presence of health conditions. From the standpoint of epidemiology, the starting point for showing that a preponderance of the evidence supports a cause-effect relationship between an exposure and a health condition is evidence that a population with a particular exposure develops a particular health condition at more than twice the rate of a population without the exposure. Comparison of development of disease in exposed and unexposed populations is stated in numerical terms as a risk indicator (relative risk (RR) in cohort studies) [12, 13]. Populations with and without a particular disease are also studied to determine if a diseased population had (a) particular exposure(s) at a rate higher than a population without the disease (case-control studies using odds ratios (OR) as risk indicators) [12]. Prevalence of disease in exposed and unexposed populations (expressed as prevalence ratio (PR) in cross-sectional studies) may also be used as an approximation of risk. [12, page 79].

Of the cohort, case-control, and cross-sectional studies, cohort studies are generally best for use in analyzing cause-effect relationships because cohort studies usually determine exposure before disease develops, and include observation of subjects through time, until they develop disease. Investigators who conduct case-control and cross-sectional studies are usually not in a position to directly or indirectly quantify exposure in the subjects that manifest disease before the onset of the disease. Thus, pre-disease exposure assessment is performed only in a cohort study making it, by far, the most valuable of the three types of studies.

A risk indicator shows that a relationship is adequately strong to support a preponderance of evidence should show that over 50 percent of the disease in an exposed population is related to the exposure. Support for a preponderance of evidence indicating that disease is caused by exposure may be present when (a) risk indicator(s) is (are) above 2.0. Another way of expressing the strength of the relationship is that the attributable risk should be at least 50 percent [14].

In our example of the widget assemblers, in Analysis IIA, the assemblers sampled in groups A and B have shoulder problems at a rate of 0.10 and 0.047, or 2.1 times more in the sampled among groups A than among group B. If other aspects of Hill Criteria are satisfied, the strength of association between assemblers in group A and shoulder problems is adequately strong to make it more likely than not that assembly activities of experienced by group A were likely to have caused the assembler's shoulder problem. This finding can be applied to the remainder of persons in group A. Using information from one group to draw conclusions about another group or about an individual is "statistical inference." Inferential statistics is the tool used by physical, medical, and social scientist and government officials to make decisions about things like the effectiveness of a drug, the impact of an infectious disease, or the future need for health care resources for a growing or aging population.

#### **Summary.**

Causation is most reliable when determined using a well-defined method and supporting data. The analysis of disease or injury causation in individuals is performed by accurate determination of a diagnosis, ascertaining exposures through history, associating the diagnosis to exposures through epidemiologic data, and quantification of exposures to assess if they have been sufficient to cause disease or injury.

Diagnosis should be determined in agreement with standard sources, such as government or professional society guidelines. Exposure is best determined by a combination of history and observation. Association between diagnosis and exposure should be supported by epidemiological data.

#### **References.**

1. Kusnetz S, Hutchison MK. A guide to the work-relatedness of disease. Pp. 1-25. US Department of Health, Education, and Welfare; Public Health Services; Center for Disease Control; National Institute for Occupational Safety and Health. 1979.
2. Work relatedness. In *Occupational medicine practice guidelines: evaluation and management of common health problems and functional recovery in workers*. Glass LS, editor. Pp. 55 to 74. American College of Occupational and Environmental Medicine. OEM Press. Beverly Farms MA. 2004.
3. Work relatedness. In *Occupational medicine practice guidelines: evaluation and management of common health problems and functional recovery in workers*. Harris JS, editor. Pp. 4-1 to 4-9. OEM Press. Beverly MA. 1998.

4. Talmage JB. Causation and apportionment: work relatedness. *Independent medical evaluation*. Grace TR, editor. Pp 67-69. American Academy of Orthopaedic Surgeons. 2001.
5. Susser M. What is a cause and how do we know one? A grammar for pragmatic epidemiology. *American Journal of Epidemiology* 133(7):635-648. 1991.
6. Greene WB. *Essential of Musculoskeletal Care, 2<sup>nd</sup> edition*. American Academy of Orthopaedic Surgeons. Rosemont IL. 2001.
7. *Primer on the Rheumatic Diseases, 12<sup>th</sup> edition*. Klippel JH, editor. Arthritis Foundation. Atlanta GA. 2001.
8. American Board of Orthopaedic Surgery. *2005 Rules and procedures for residency education part I and II examinations*. Chapel Hill, NC. 2004.
9. Louis DS. Two views of musculoskeletal symptoms in the workplace – A question of causality. *American Academy of Orthopaedic Surgeons Bulletin* 44(1):
10. Vermont Statutes, Title 21, Chapter 9, Section 601 (23). Vermont Statutes Online. State of Vermont. <http://www.leg.state.vt.us/statutes/fullchapter.cfm?Title=21&Chapter=009>. Accessed April 20, 2005.
11. Vermont State File No. J-15842 Department Of Labor And Industry State Of Vermont. Petit v. North Country Union High School. <http://www.state.vt.us/labind/wcdecisions/1998/J15842petit.txt>. Accessed April 20, 2005.
12. Measures of disease frequency and association: measure of association: relative risk. In *Epidemiology and medicine*. Hennekens CH, Mayrent SL. Pp 77-82. Little, Brown. Boston. 1987.
13. Measures of disease frequency and association: interpretation of measure of association: attributable risk. *Ibid* Reference 13. Pp 93-95.
14. Measures of disease frequency and association: measure of association: attributable risk. *Ibid* Reference 13. Pp 87-93.
15. Ergonomics guidelines. Appendix B (WMSD hazards analysis). Washington State Register: WSR 00-12-024. WAC 296-62-05174. <http://slc.leg.wa.gov/wsr/2000/12/00-12-024.htm>. Accessed May 8, 2004.
16. McAtamney L, Nigel Corlett E. RULA: a survey method for the investigation of work-related upper limb disorders. *Applied Ergonomics* 24(2):91-9. 1993.
17. Kroemer KHE. Ergonomics. In *Fundamental of industrial hygiene, 4<sup>th</sup> edition*. Plog BA, Niland J, Quinlan PJ, editors. Pp. 347-401. National Safety Council. Itasca IL. 1996.

18. Drinkaus P, Sesek R, Bloswick D, Bernard T, Walton B, Joseph B, Reeve G, Counts JH. Comparison of ergonomic risk assessment outputs from Rapid Upper Limb Assessment and the Strain Index for tasks in automotive assembly plants. *Work* 21(2):165-72. 2003.
19. Mausner JS, Kramer S. Epidemiologic orientation to health and disease: epidemiology defined. In *Mausner and Bahn Epidemiology – an introductory text, 2<sup>nd</sup> edition*. Pp. 1. WB Saunders Company. Philadelphia. 1985.
20. Hendrick HW. Ergonomics: an international perspective. In *The occupational ergonomics handbook*. Pp. 3-15. Karwowski W, Marras WS, editors. CRC Press. New York. 1999.
21. DeGowin RL, Brown DD, Christensen J. Diagnosis. In *DeGowin and DeGowin diagnostic examination, 6<sup>th</sup> edition*. Pages 1-11. McGraw Hill, Inc. New York. 1994.

