



I O W A H O S P I T A L A S S O C I A T I O N

September 22, 2005

Michael G. Trier
Workers' Compensation Commissioner
Division of Workers Compensation
Iowa Workforce Development
1000 East Grand Avenue
Des Moines, IA 50319-0209

Dear Commissioner Trier:

On behalf of the members of the Iowa Hospital Association (IHA) and the Iowa Medical Society (IMS), thank you for agreeing to meet with our organizations on September 29 to discuss workers compensation carriers' discounts from provider charges. The purpose of this letter is to provide background on the situation in preparation for our discussion.

As you know, the Iowa Administrative Code r. 876—10.3 allows for an informal dispute resolution process that establishes procedures for resolving a dispute between a provider and a responsible party over the treatment rendered by a provider to an injured worker. This regulation defines a dispute as a disagreement between a provider and responsible party over the necessity of service or reasonableness of charges or both. Hospitals and physicians alike have contacted our associations recently to express concern with the significant discounts these carriers are taking from billed charges (in absence of a contractual agreement with the provider) based on databases unknown to the hospital or physician but claimed by the carriers to show that charges are in excess of "usual and customary". Although the informal dispute resolution process of rule 10.3 affords an opportunity for providers to contest these decisions, the fact is that despite being in place for nearly 15 years, Iowa providers find the process cumbersome and unworkable. In disputing discounts taken by workers compensation carriers, only one case can be addressed at a time. Often the amount in dispute in a singular claim does not warrant the level of resources needed to manage the dispute process. However, recent activity has suggested that the aggressive nature of the carriers and the significant discounts being taken merit re-examination of the process or other mechanisms for relief.

Therefore, the primary aspect of our discussion on September 29 is the process itself and the requirements governing the dispute resolution, as well as the Division's perspective on the practices being utilized by the carriers. Some of our specific questions include:

1. What constitutes sufficient compliance with the requirement in 876—10.3(3)"b"(5) to provide the documentation relied upon to formulate the belief that a provider's bill is excessive or unnecessary? Recent correspondence from compliance administrators within the Division indicate that a mere summary statement from the carriers that the amount billed exceeds the usual and customary charge is not sufficient. However, a frequent statement of explanation in reducing charges is "this fee was reviewed to a standard of reasonableness based on comparisons to industry benchmarks of charges and reimbursement for comparable services in your area." In reviewing one company's reductions, the same charge by the same provider is reduced to varying amounts utilizing the same explanation. What is the Division's position on what constitutes "reasonable" charges?

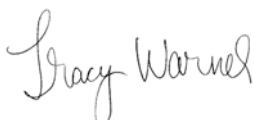
2. Is the Division aware of cases that have been resolved using the informal dispute resolution process? If so, what have been the outcomes? What types of individuals have been utilized to conduct the review(s)? Does the Division maintain a list of reviewers? According to the 876—10.3(9)"d", a person other than the persons recommended may be chosen at the discretion of the Workers' Compensation Commissioner.
3. Does the Division have any jurisdiction over the third parties utilized by workers compensation carriers to review provider charges? It appears that these organizations are essentially unregulated and, as such, may be qualified or unqualified to provide detailed analysis of provider charges. Further, we understand the compensation arrangements with these organizations is contingency-based, which provides an incentive for finding reductions through whatever means may be achievable.
4. From the provider billing perspective, the explanations provided for the reductions/denial are inaccurate and do not represent standard billing practices. Is the Division amenable to working with hospitals and the medical community to provide education in this arena?

Iowa providers have traditionally been efficient, providing low cost, yet high quality care which is the reason they have been dumbfounded by the explanations that charges are beyond the usual and customary, especially when the reductions are reaching beyond just ten or fifteen percent, and extending to fifty or more percent of charges. In addition to expenses incurred in providing patient care, providers face a constant demand to keep pace with rapid advances in medical care and to replace outdated or obsolete facilities and equipment, as well as address the costs of recruiting and retaining employees. These expenses are reflected in providers' charge structures for services, as well as the increasing payment shortfalls from Medicare and Medicaid that do not reimburse at a level that covers the cost of providing care. Yet, because of the low reimbursement rates, providers are unable to appropriately respond to many of these increasing costs. Carriers and third party reviewers that are subjecting Iowa provider charges to national databases to determine payment levels simply do not recognize the dynamics of the health care landscape in Iowa where the medical community is highly dependent on government programs.

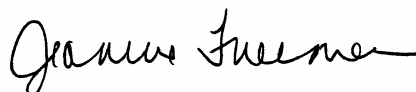
As time allows, we also would like to briefly discuss two other issues: 1) an update on the medical record fee schedule set forth in rule 876-8.9 and 2) the Division's expectations re: use of its authorization form for release of a medical information in workers' compensation cases. While the provider community remains accepting of the standard medical record fee schedule set forth in the rules, their expenses in maintaining and managing a medical records system have only increased since adoption of the rule over a decade ago. On the issue of the Division's authorization form, providers continue to receive requests for "any and all" medical record information but, absent authorization from the patient, are reluctant to release information in response to such a broad-based request given the language of Iowa Code section 85.27(2) that affords immunity protection for the release of medical information *relative to the claim*. Is the Division encouraging attorney use of its form and is it appropriate for providers to direct attorneys and others to the form?

We look forward to our forthcoming discussion and your assistance in addressing these matters on behalf of Iowa providers and the patients they serve.

Sincerely,



Tracy Warner
Vice President, Finance Policy
Iowa Hospital Association



Jeanine Freeman
Senior Vice President of Legal Affairs
Iowa Medical Society