NEW YORK STATE ASSEMBLY STANDING COMMITTEE ON LABOR
ASSEMBLYMAN CARL E. HEASTIE, CHAIR

NEW YORK STATE ASSEMBLY STANDING COMMITTEE ON INSURANCE
ASSEMBLYMAN KEVIN CAHILL, CHAIR

TESTIMONY OF WILLIAM M. PURDY, ESQ., NEW YORKERS FOR FAIR AUTOMOBILE INSURANCE REFORM (NYFAIR) DECEMBER 19, 2014

Regarding the Proposed Changes to the Workers Compensation Fee Schedule

On behalf of New Yorkers for Fair Automobile Insurance Reform (NYFAIR), we thank you for this opportunity to address the New York State Standing Committees on Labor and Insurance regarding the Workers Compensation Board's proposed changes to the Schedule of Medical Fees. NYFAIR's mission is to ensure that New Yorkers have continued access to quality medical care to help motorists and pedestrians obtain the treatment needed to recover from injuries sustained in automobile accidents. Members of NYFAIR are affiliated with various doctors' advocacy groups, hospitals, medical professional practices, trade groups, bar associations and concerned citizens. All told, the members of NYFAIR represent thousands of medical professionals throughout the State of New York.

While we applaud efforts to assess and improve the Workers Compensation system, and by extension, the No-Fault Insurance system[1], we oppose the adoption of a resource based relative value scale (RBRVS) based fee schedule used by Medicare for Worker's Compensation and No-Fault Insurance claims.

[1] NY Ins Law § 5108(a), with rare exception, limits charges for health services provided to automobile accident victims to the schedules adopted by the chairman of the workers compensation board.

As you will see from our testimony, the comparison to RBRVS is built on a series of badly flawed assumptions, conclusions that ignore reality, and an effort to create "parity" where none exist. We will demonstrate the following:

1. A sick Medicare patient is not the same as a worker or auto accident victim who suffers trauma.

2. The billing practices required by Medicare and those required by NYS WC and auto insurers are vastly different.

3. The payment practices of Medicare and NY comp and auto insurers are wildly disparate.

4. The time required to obtain payment, and collection efforts necessary to do so, are nothing alike.

Treatment and payment of Medicare patients is like taking a bullet train; treatment and payment of an injured worker or motorist is like taking a tricycle. To suggest the fares should be the same is absurd. As recognized in the Committees' Notice of Public Hearing, such proposed change would reduce the payments to a number of practitioners whose skills help rehabilitate workplace and automobile accident victims, such as orthopedic surgeons, radiologists and other medical practitioners. As aptly set forth in the Committees' notice, "there are concerns that reducing reimbursement rates for these services would cause providers to withdraw from the workers' compensation system, causing a reduction in the quality of accessible providers and services."

To be blunt, your hearing notice is spot on. If the fee schedule were adopted, it will not serve the needs of injured employees and automobile accident victims, it will substantially reduce the number of skilled and dedicated medical providers who readily accept and treat workplace and automobile accident victims.

When injured people are deprived the care necessary to heal, it means workers cannot return to work, causing harm to the businesses who rely on their workforce to meet the needs of their clients and customers. This regulation would harm businesses that employ those hurt in workplace or motor vehicle accidents, and the public in general.

I. **No True Parity Among Patients**

There is good reason for a disparity between the schedules for Workers Compensation and the RBRVS utilized by Medicare. Medicare's patient population is primarily the chronically ill and the elderly, a population that is generally well served by primary care providers such as internists and family general practitioners. The typical Medicare patient is rarely a trauma victim.

In contrast, most patients seeking treatment for workplace or automobile accident related injuries are typically otherwise healthy individuals who have suffered acute musculoskeletal injuries. Many have injuries to the neck, back, shoulder, knee, hand or foot, and require the services of specialists. They are not sick, they are injured.

The proposal suggested by the Workers Compensation Board would shift reimbursement away from the very specialists required to return the injured to the work force, in favor of the general practitioners. Reducing fees for these specialists would discourage participation in the Workers Compensation and No-Fault systems and would reduce access to quality health care.

II. No True Parity Among Payers

The 7/11/2014 release version of the proposed Workers Compensation fee schedule changes as well as the Workers Compensation Board's 7/28/2014 bulletin regarding the proposed changes inaccurately assumes or suggests parity among Medicare claimants and their physicians with workers compensation and no-fault claimants and their physicians, without an accounting of the actual reimbursement dynamics of either Workers Compensation claims or No Fault claims.

The WCB (Workers Compensation Board) has incorrectly characterized current reimbursement rates as being in need of realignment based on a comparison of market rates. But the WCB has failed to compare the dynamics behind the billing, administration, collection, and litigation of unpaid claims associated with No-Fault and Workers Compensation claims with those of the Medicare system. To equate national payer sources with New York State workers compensation and no-fault insurance carriers is frankly absurd. One must look closely at the submission, administration, and collection dynamics of Medicare providers and payers and compare those to providers who treat those injured in auto and workplace accidents, and the carriers who in theory are supposed to pay those claims. To suggest the two systems are similar is grossly inaccurate, and any attempt to equate the two is completely meritless.

The costs associated with the billing, submission and collection efforts of medical providers are compounded by the already low voluntary payment rate by the insurance companies. Slow payment is exacerbated by the routine use of adversarial claims practice by insurance carriers. There are epic delays in obtaining a judicial decision and the remedies available to medical providers for adjudication of unpaid claims greatly distinguishes Workers Compensation and No-Fault claims from this global market comparison to Medicare.

To put it simply, Medicare is a reasonably reliable payer, and the process is generally reliable. Workers comp and auto insurers are at best notoriously slow payers; they stonewall, they litigate, they deny legitimate claims, and obtaining payment often

requires Herculean collection efforts. The resources required to process these claims, and the denial rates and subsequent aging of open receivables, is vastly different for a health care provider treating an injured accident victim than it is for a health care provider treating a sick Medicare patient. There is simply no comparison. And that is why seniors do not struggle to find providers who accept Medicare.

A few examples follow:

- No-Fault claims cannot be submitted electronically and require strict adherence to the statutory timely for submission (as well as strict statutory compliance with verification responses) that require submission logs, retention of postal proofs of mailing, and/or some verifiable proof of submission to the carrier to establish entitlement to reimbursement.

- No Fault claims must be submitted on a three-page form promulgated by the Department of Financial Services (DFS). No Fault claims processing is subject to verification requests by the no-fault insurance carrier for virtually anything the carrier can allege is *necessary* to process the claim. Any particular bill, regardless of the bill amount, is subject to the request by a carrier for information that can range from 1-20 distinct medical and corporate documents as well as the potential for testimony at an examination under oath (EUO). While the No-Fault Regulations allow for the submission of the functional equivalent of the NF-3 billing form, major insurance carriers respond to ALL such billing with an automatic, knee jerk verification request, which includes a demand for the statutory form, regardless of the sufficiency of the information included in the original submission.

- No-Fault claims have an overwhelmingly large ratio of denials to voluntary payments, requiring litigation efforts that seek judicial intervention or intervention through Arbitration.

- By accepting a No-Fault assignment by a patient, and with limited exception, the medical provider is limited to pursuing payment only from the insurance carrier in the event there is a denial, as opposed to asserting patient responsibility. That means if the carrier fails to pay, the provider must either incur substantial collection costs, or eat the loss.

- Workers Compensation claims must be submitted on various statutory forms, which include filing deadlines on initial visits within 48 hours, encompassing narratives, treatment and follow up evaluations.

- The implementation of the Medical Treatment Guidelines (MTG) in December of 2010 has resulted in mass confusion by insurance carriers with no clear set guidelines for claim review.

- Medical providers seeking confirmation for services subject to the MTG must either request the service's authorization through an MG-1 form or perform the service real-time but submit a request for a variance. In either event, the claims personnel and utilization reviewers used to process these requests rarely agree on the application of the respective MTG section to be applied, further delaying reimbursement. Our members must expend a tremendous amount of administrative staff support to convince the carriers to allow treatment with little formal adjudication.

- The implementation of the MTG has resulted in a six-fold increase in disputed claims submitted to the WCB for adjudication through an HP-1 (a result of the carrier having failed to pay or deny a claim). Insurance carriers have used the MTG's as a large shield from which they stop payment to our members. Again, this forces our members to employ staff and resources to obtain payment from the carriers. Our members are offered a limited administrative remedy and that remedy has been significantly taxed since the implementation of the MTG's.

- The WCB currently is experiencing a 16-18 month delay in processing an HP-1 form submitted by a medical provider.

- A medical provider is currently NOT considered a party of interest for purpose of following a compensation case's progress on the WCB web portal. Often our members are left to treat accident patients for months before discovering the insurance carrier will not being paying their bills. The lack of communication between the workers' compensation board and our members further compounds the billing and collection efforts our members must endure while treatment a patient injured as a result of a work related injury.

- Even when our members are awarded a decision from the workers compensation board, the process to obtain a judgment is extremely arduous. Once the HP-1 has been authorized to our clients, they are required to submit another form with the board for authorization to convert the workers compensation decision into a judgment. The form is then filed in court and then to a Marshall for forcible execution on the judgment, if necessary. This reimbursement model is completely divergent from other insurances and requires significantly more time and energy.

III. **Litigation and Arbitration**

While the study by the WCB seeks to impute parity between No-Fault and Workers Compensation to other national payer reimbursement rates, no mention is made of the fact that the commercial contract reimbursement rates which are guided by Medicare are almost entirely preauthorized with a virtually guaranteed payment (often through EFT within 2-3 weeks of service). Accordingly, while the current No-Fault and Workers Compensation reimbursement rates exceed the reimbursement rates followed by Medicare and subsequently by commercial plans, a medical provider submitting No-Fault and/or Workers Compensation claims can expect to collect only a small percentage within the initial submission time-frame. Simply put, it takes a lot more time to collect a lot less money.

Providers are then tasked to pursue the unpaid bills through arbitration or litigation: both are expensive, time consuming and divert resources that would be better allocated towards patient care. Ironically, this low voluntary pay rate does not inure to the carriers' benefits, as the vast majority of claim presented to a judge or arbitrator are ultimately resolved in favor of the health care provider.

However, during this time consuming process, the medical provider is forced to carry the open receivables until the matter can be resolved. Couple this with the proposed reduction in fees, and it will be little wonder that most medical providers who currently treat accident victims on a regular basis are likely to refuse to accept any such patients in the future.

While the WCB proposal presents its assumptions and supporting documentation with the goal of realigning a purportedly misaligned system, this myopic view clearly takes no account of its ramifications upon implementation, much like the implementation of the MTG. Inarguably, the system is already burdensome, and in many cases a provider will accept these patients as a loss-leader merely to accommodate patients or referral sources. However, as discussed, to assume the current No-Fault and Workers Compensation reimbursement rates require alignment to a system that is completely different, and which carries none of the same administration, belies logic. The providers will have no choice but to refuse treatment of work related and auto accident injuries and ultimately, the patients' access to care will be negatively impacted, running contrary to the legislative intent of the statutes.

Finally, to say that as a result of the fee schedule remaining unchanged for 20 years, "some providers and services are vastly overcompensated . . ." (WC Board bulletin dated July 28, 2014) makes absolutely no sense. The exact opposite is true! In the eighteen years since 1996, the cost of running a medical office, including salaries, rent, equipment rentals and purchases, supply purchases, liability insurance and other expenses, has

increased dramatically. Thus, to not only fail to increase fees for certain services in the wake of inflation, but instead to decrease them, will surely be the death knell to accessible medical care for injured workers and automobile accident victims.

This should trouble every Legislator. Both the Workers Compensation and No-Fault laws are predicated on a similar bargain: injured people give up the right to sue, in exchange for prompt and certain treatment. But if these fee schedules are adopted, injured workers and motorists will have suffered a double whammy. They will have lost the right to sue, and will find a chronic scarcity of providers willing to treat them. Policymakers must not let that happen.

Thank you.

Respectfully submitted,

William M. Purdy