pra
Progressive Rehabilitation Associates

20 Years of Excellence
Multidisciplinary Pain Management
Work Hardening/Conditioning
Brain Injury Rehabilitation Center

1815 SW Marlow, Suite 110 • Portland, Oregon 97225 • 503-292-0765 • 800-320-0681 • fax 503-292-5208

March 15, 2013

Senate Committee on General Government, Consumer and Small Business Protection
RE: Senate Bill 686

In spite of the Unfair Claims Settlement Act of 2011 (ORS 746.230), insurers continue to make seemingly arbitrary decisions about payment of claims for medical services, fail to respond to attempts to clarify any issues with claim submission, and make decisions about reimbursement that have had significant impact on practices. I give the following examples as evidence.

In our practice, we see patients with chronic pain or acquired brain injury. Payment for the multidisciplinary medical rehabilitation services comes from a variety of sources, including worker's compensation insurers, commercial insurers, state vocational rehabilitation, private payment, etc. At any given time, our accounts receivable will have as much as 10 to 25% of the outstanding payments due greater than 90 days after the service was rendered. Sometimes the error is ours, such as not using the right modifier with the procedure code, or sending the claim to the wrong processing address for the company. Often though, and more particularly so with third party administrators or smaller worker's compensation insurers, we find that we've done everything according to standard, but in their processing of the claim we find ourselves repeatedly submitting bills and documentation, returning checks for incorrect payments, and leaving multiple voice mails with claims managers and their supervisors with no return phone call or other communication. At present, we have nearly $32,000 in claims that are greater than 120 days from date of service owed by three insurers, one of whom has a national presence. This may not seem like much to a large practice, but to a small practice, this amount is approximately 20% of our monthly payroll cost alone.

In another example, we received a copy of a letter to an injured worker notifying them of the finding that their injury was judged "medically stationary". While there is no specific date of effect noted in the letter, the letter is dated 3/11/13, so this educated reader is left to assume that the date of the letter is the determination date. We received the copy of the letter because we have outstanding claims from 1 year ago that remain unpaid. Receipt of the letter now prompts our billing staff to file yet another appeal to have the claims paid because the dates of service occurred before the date on the letter. However, because there is no date certain concerning the finding of "medically stationary", we will need to again state our case for why we should receive payment for services rendered.

In a different example of insurer decision making that has impacted practices, in the past two years one of the state's largest insurers made the decision to reduce the reimbursement for medical rehabilitation services. While larger organizations with a variety of insurance contracts were able to absorb this

reduction, many small practices were not. I am aware of at least one SLP in the Portland area who made the painful decision to close her pediatric focused practice, and a handful of others around the state that could no longer afford to employ the number of therapists they had in spite of the demand for services. This left families with children needing therapy services greater than can be provided in the schools with fewer choices in larger communities and perhaps none in more rural areas. While the insurer sent the necessary notice to all enrolled providers prior to implementing the reduction, practices were still caught off guard. In the scope of a busy clinic day, without the benefit of a department charged with managing compliance and contracts to address these communications, this letter would be yet another "Provider Update" that goes in the stack of things to get to when there's time. This does not excuse failure to respond to such notices, but even if a practice does respond in a timely manner, getting a response from the contracts department to renegotiate is another matter altogether. I have given up on getting a response from the contracts person assigned to our organization in a situation that they initiated. In the scope of my day as a practice administrator, I'm dealing with a variety of situations and wear a multitude of hats.

I support the efforts of this bill to include insurance companies in the category of business types subject to unlawful trade practice penalties. Need for a service should not allow for exemption from the same fair trade practices to which so many other types of services are held.

Respectfully,

Kathy de Domingo, MS, CCC-SLP, FACMPE

Kathy de Domingo, MS, CCC-SLP, FACMPE
Director of Performance Improvement