calhoon & associates, p.c.

Trusted Answers • Peace of Mind

www.workinjuryinpa.com

THE ALMOST HASSLE-FREE WAY TO COLLECT PA WORKERS' COMPENSATION MEDICAL BILLS

This book has the forms and guidance to get your workers' compensation medical bills paid.

THE ALMOST HASSLE-FREE WAY TO COLLECT PA WORKERS' COMPENSATION MEDICAL BILLS

Harrisburg, PA
Telephone: 877-291-WORK (9675)
Web address: www.pa-workers-comp-lawyers.com

PRINTED IN THE UNITED STATES OF AMERICA

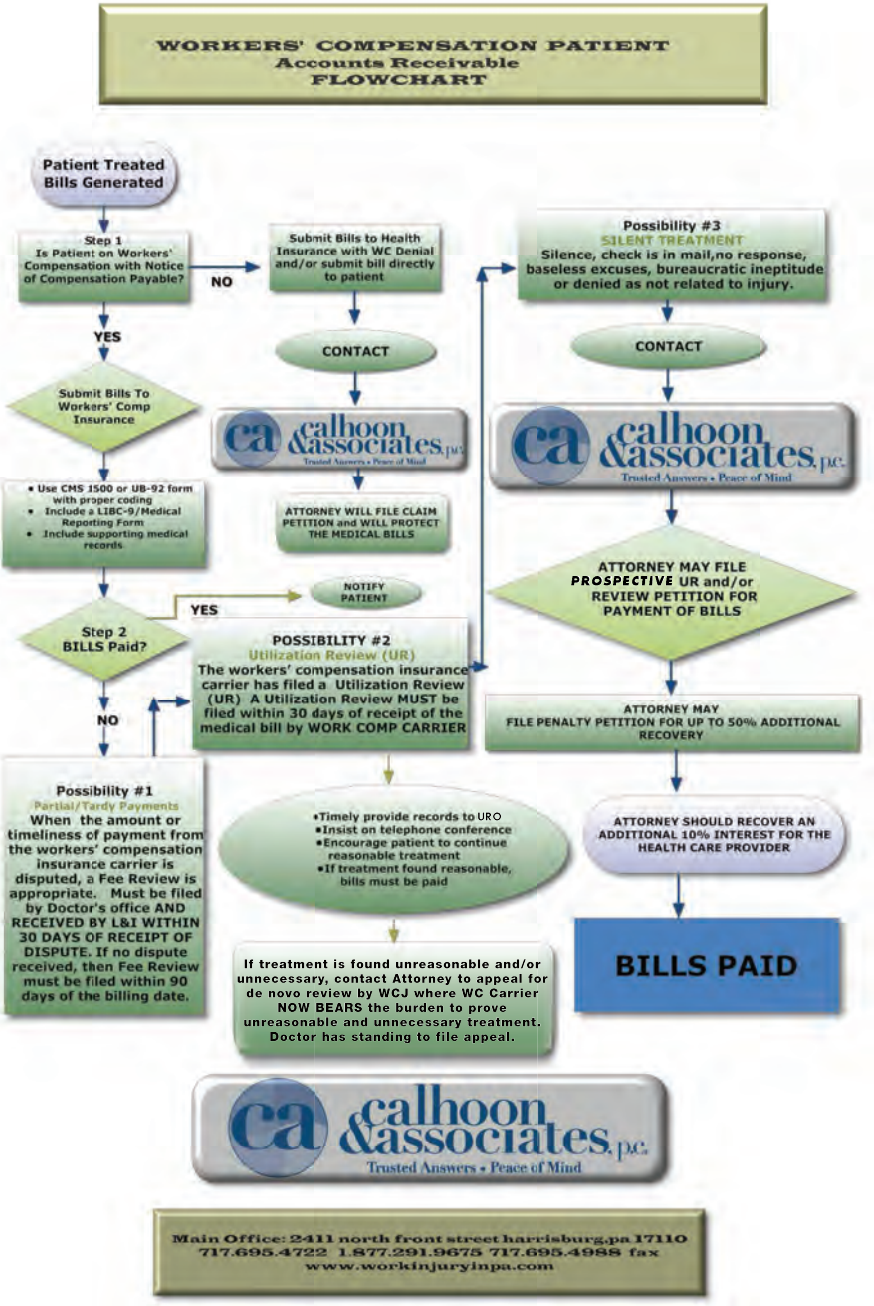
ACKNOWLEDGEMENT AND DEDICATION

This book was written for medical providers and injured workers to find peace of mind in what can be a frustrating and confusing area of workers' compensation law. Doctors need to treat and injured workers need to get better. Hassles over medical bills does not serve these goals. Hopefully, this book will help.

A heartfelt thanks to Diane Hovan who has helped write this book and has, as a workers' compensation paralegal, tirelessly and patiently helped get many thousands of medical bills paid for our injured clients free of charge.

All profits from the sale of this book will be donated to the Calhoon & Associates Trusted Answers Piece of Mind College Scholarship offered through Kid's Chance of Pennsylvania which provides educational scholarships to children who have had a parent killed or severely injured while performing work duties.

THE ALMOST HASSLE-FREE WAY TO COLLECT PA WORKERS' COMPENSATION MEDICAL BILLS



INTRODUCTION

What follows is a guide on the basics of obtaining payment for medical bills in Pennsylvania workers' compensation matters. Medical billing in workers' compensation matters can be an unfamiliar and uncertain task. What is the process? What forms are to be used? What happens if payment is not timely or is denied? What are the time limits? Some common complaints are: workers' compensation never pays on time, denies submissions, fails to pre-approve treatment, or just ignores the bill. Sometimes, it just seems easier to avoid dealing with workers' compensation. However, this book is here to help you. Knowledge makes all the difference.

STEP 1:
PROPERLY SUBMIT THE BILLS

When a patient first presents to you stating they suffered a work injury, you must get some crucial information from them. Ask them for their employer's name, address, and phone number. Next, ask for the workers' compensation carrier's name, address, and phone number. You will also need the claim number and the date of injury.

The patient should be asked to provide their Notice of Compensation Payable, Notice of Temporary Compensation Payable or a Workers' Compensation Judge's award recognizing the work injury. These documents will provide all of the above crucial information and, more importantly, confirm that the patient has an accepted workers' compensation injury.

If the injury has been accepted, workers' compensation pays for all reasonable, necessary and work-related medical treatment by "practitioners of the healing arts". The Notice of Compensation Payable issued by the workers' compensation insurance carrier describes the injury under the heading "Description of Injury" and "Body Parts" on the top left side of the form. Please keep in mind that workers' compensation is only required to pay for treatment which falls within the "Description of Injury" and "Body Parts". For example, if the injury is described as a cervical strain, workers' compensation must pay for treatment to the neck. However, if the treatment being billed to workers' compensation is to the right shoulder, workers' compensation is not automatically responsible for payment. Some exceptions exist, such as when

a test is performed to another body part to rule out causes for the work injury or pre-surgical testing. Knowledgeable counsel can help when such questions arise. Further, if the patient's doctor feels that a condition not described on the Notice of Compensation Payable is work related, there are legal methods available to have the treatment paid for by workers' compensation.

If the treatment or injury is denied as not work related, you may bill the patient's private health insurance, Medicare or other government-sponsored health insurance. This is prudent for many reasons; most importantly, it protects the patient's health and workers' compensation claim by allowing them to continue treatment during denial by workers' compensation. Besides lower reimbursement rates, drawbacks to billing sources other than workers' compensation include:

- Unnecessary and costly co-pays to patient;
- Unnecessary and costly deductibles to patient; and
- Maximum private health insurance benefits attained prematurely, precluding further treatment for any condition over the patient's lifetime.

If a medical bill is denied by workers' compensation as not work related, a provider can then bill other insurance. The Commonwealth of Pennsylvania issued two (2) memorandums regarding the Insurance Department's regulations governing the use of exclusions for workers' compensation insurance in accident and health insurance (attached). **These regulations require health insurance companies to pay claims if the workers' compensation insurance company refuses coverage.** If the health insurance company refuses to pay "because the treatment is work-related," a letter enclosing

these two (2) memos almost always causes quick payment. If private health insurance and/or government-sponsored insurance is billed during the course of litigation, in the event of a favorable Decision, workers' compensation will be required to repay the private health insurance. Sometimes this is done by the workers' compensation insurance carrier issuing a check directly to the private health insurance. The workers' compensation insurance carrier can also make payments directly to the medical provider, who, in turn, will need to reimburse the patient's private health insurance accordingly.

A sample letter to the health insurance provider and the two memorandums addressing the use of exclusions for workers' compensation follow this paragraph. Also, a sample of a Notice of Compensation Payable and a Temporary Notice of Compensation Payable are shown on the next three pages.

Date

Health Insurance

Re: _____ **vs.** _____
Subscriber Name:
Insured ID:
Group No.:
Date of Injury:

Dear Sir or Madame:

I am in receipt of your _____ letter in the above-referenced matter denying payment for Mr. _____'s claims as they are for a work-related injury. Mr. _____'s workers' compensation claim has been denied and is in litigation.

Enclosed please find two (2) memorandums issued by the Commonwealth of Pennsylvania stating that a private health insurance carrier is prohibited from denying a patient's claims if the workers' compensation carrier has denied liability. Therefore, please make appropriate payment on Mr. _____'s claims.

If you should have any questions or wish to discuss this matter further, please do not hesitate to contact me.

Very truly yours,

Ronald L. Calhoon
rcalhoon@pa-workers-comp-lawyers.com

/
Enclosures

October 24, 1991

Subject: Coverage Disputes Between Workers' Compensation Insurers and Accident and Health Insurers

To: Carl Lorine, Director
Bureau of Workers' Compensation

From: Patrick Musick, CPCU
Bureau Director
Property and Casualty Insurance

As was discussed at length in today's meeting, the Insurance Department has two regulations governing the use of exclusions for workers' compensation insurance in accident and health insurance. The relevant regulations are: Title 31 §88.84(1)(iii) and §89.77(1)(iv). The Bureau of Accident and Health Insurance has consistently interpreted the language in the regulations to require that A & H companies pay claims if the workers' compensation carrier refuses coverage. The forms supervisors in the Bureau have confirmed that policy forms for accident and health insurance are consistent with this interpretation.

If an accident and health insurer refuses to pay a claim when a workers' compensation carrier has denied coverage, then our Consumer Services Bureau can be called, and they will take appropriate action to have the accident and health insurer provide its policy's benefits to the insured.

It is our understanding that you plan to publicize the Insurance Department's role in this matter and its regulations by informing your referees and including an attachment to workers' compensation claimants when a claim has been field with L & I.

The Insurance Department has four Consumer Services Offices in the Commonwealth. The locations and telephone numbers are:

Philadelphia	215-560-2630
Pittsburgh	412-565-5020
Harrisburg	717-787-2317
Erie	814-871-4466

The Bureau Director for Consumer Services is Gregory Martino, and he can be reached at the Harrisburg office.

cc: Gregory Martino

L:\HOME\ROXANNE\RONPACKETS\102491.MEM

Commonwealth of Pennsylvania

DATE: October 29, 1991

SUBJECT: Accident and health Coverage Disputes

TO: All Workers' Compensation Referees
All Senior Staff
All Hotline Staff
All Legal Staff

FROM: Carl M. Lorine, Director
Bureau of Workers' Compensation

It has come to our attention that some accident and health insurance companies are refusing to pay benefits for a specific injury or illness during the pendency of workers' compensation litigation concerning the same injury or illness. Apparently the theory is that although the workers' compensation carrier has denied liability, the claimant is excluded from coverage under the accident and health policy since he has filed a workers' compensation claim for the same injury or illness.

Our Insurance Department recently advised that such activity on the part of the accident and health carriers is prohibited. They point to their regulations which have been interpreted to require that the accident and health carriers make payment once the workers' compensation carrier denies liability. (See attached memorandum dated October 24, 1991.)

I would ask the Referees to post in their Hearing Rooms the Insurance Department's memorandum dated October 24, 1991 entitled: "Coverage Disputes Between Workers' Compensation Insurers and Accident and Health Insurers." If this issue comes to your attention, please refer all parties to Gregory Martino, Director of Consumer Services, Insurance Department, (717) 787-2317.

Attachment

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

NOTICE OF COMPENSATION PAYABLE

DATE OF NOTICE
MM DD YYYY

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

DATE OF INJURY
MM DD YYYY

WCAIS CLAIM NUMBER

EMPLOYEE

First name
Last name
Date of birth
Address
Address
City/Town State ZIP
County
Telephone

EMPLOYER

Name
Address
Address
City/Town State ZIP
County
Telephone FEIN

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name
Address
Address
City/Town State ZIP
County
Telephone FEIN
Contact
NAIC code or Insurer code
Insurer/TPA claim #

INJURY INFORMATION

Part of body injured
Nature of injury
Accident/injury description narrative
Check if occupational disease ☐

NOTICE TO EMPLOYER: This Notice should be clearly completed, (preferably typed) and filed with the Bureau. Filing with the Bureau by electronic batch upload in WCAIS, by electronically attaching the document to a claim in WCAIS, or by mail. A copy must be sent to the injured employee with the first payment of compensation.
NOTICE TO EMPLOYEE: If any questions arise regarding these payments, contact the representative named at the bottom of this Notice. If you cannot resolve a problem with the employer representative, you may call the Bureau at 800-482-2383.

Compensation is payable as follows:

☐ Check only if compensation for medical treatment **(medical only, no loss of wages)** will be paid subject to the Workers' Compensation Act. Compensation for medical treatment is payable from date of injury.
For compensation for medical treatment only, you should not complete numbers 1 through 5.

1. Weekly compensation rate $ Based on an average weekly wage of $
2. Payments begin on MM DD YYYY (Compensation for loss of wages is payable for first 7 days only if disability extends 14 or more days; compensation for medical treatment is payable from the date of injury.)
3. Date first check mailed MM DD YYYY if the date exceeds the 21-Rule, check this box ☐ and explain on back of this form.
4. Payments will hereafter be made: ☐ Weekly ☐ Biweekly ☐ Other (Specify):

Any termination, suspension or modification of these payments must be made by agreement, final receipt, administrative or judicial determination, or as otherwise provided in the Workers' Compensation Act or Regulations of the Department.

(OVER)

LIBC-495 REV 09-13 (Page 1)

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

NOTICE OF TEMPORARY COMPENSATION PAYABLE

DATE OF NOTICE
MM DD YYYY

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

DATE OF INJURY
MM DD YYYY

WCAIS CLAIM NUMBER

EMPLOYEE

First name
Last name
Date of birth
Address
Address
City/Town State ZIP
County
Telephone

EMPLOYER

Name
Address
Address
City/Town State ZIP
County
Telephone FEIN

INJURY INFORMATION

Part of body injured
Nature of injury
Accident/injury description narrative
Check if occupational disease ☐

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name
Address
Address
City/Town State ZIP
County
Telephone FEIN
Contact
NAIC code or Insurer code
Insurer/TPA claim #

NOTICE TO EMPLOYER: In wage loss claims, a copy of the Notice is to be sent to the injured employee with the first payment of **temporary** compensation. The original must be filed with the Department of Labor & Industry. Filing with the Department may be completed by electronic batch uploaded in WCAIS, by electronically attaching the document to a claim in WCAIS, or by mail. In wage loss claims, the 90 day period begins on the first day of disability. The employer's/insurer's failure to file a notice as provided in Section 406. 1(d)(5) of the Act advising the employee that the employer is ceasing temporary compensation shall be deemed an admission of liability, and this notice shall be converted to a Notice of Compensation Payable.
NOTICE TO EMPLOYEE: This Notice of **temporary** compensation payments is for a period of up to 90 days and **is not** an admission by your employer that it is responsible for your injury. If any questions arise, contact the representative at the bottom of this Notice. If you need further information, call the Bureau at 800-482-2383.

Compensation is payable as follows:

☐ Check only if compensation for medical treatment **(medical only, no loss of wages)** will be paid subject to the Workers' Compensation Act. Compensation for medical treatment is payable from date of injury. If employer stops temporary compensation in accordance with the Act, employer will not pay for treatment received on or after the stoppage date. For compensation for medical treatment only, you should not complete numbers 1 or 3.

1. Weekly compensation rate $

   Based on an average weekly wage of $ (A statement of wages must accompany this form.)

2. Ninety-day period begins on MM DD YYYY and ends on MM DD YYYY

3. Payments will hereafter be made: ☐ Weekly ☐ Biweekly ☐ Other (Specify)

   until payments cease or the ninety-day maximum period for temporary compensation expires.

Claims representative's name _____ Telephone _____

Claims representative's signature (OVER)

LIBC-501 REV 09-13 (Page 1)

After the patient has been seen by the physician and a HCFA 1500 or UB has been created, you need to fill out an LIBC-9. Remember, this is a two-sided form even though you are only filling in one side. You should then mail the bill, LIBC-9, itemized bill, and medical records to the workers' compensation carrier. An itemized statement or standard billing summary means nothing to the workers' compensation insurance carrier! The itemized statement or billing summary are not sufficient requests for payment, and can legally be ignored. **Compliance with the requirement that a completed LIBC-9 be sent with the bills is a prerequisite to the carriers' obligation to process and pay the medical bill!**

A sample copy of both sides to the LIBC-9 form can be found on the next two pages.

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

WORKERS' COMPENSATION MEDICAL REPORT FORM

THIS FORM IS TO BE FILED WITH THE EMPLOYER OR INSURER ACCORDING TO INSTRUCTIONS PROVIDED ON THIS FORM.

Name of employee _____

Name of employer _____

Name of insurer _____

WCAIS claim number _____ Date of birth _____

Employee SS# XXX-XX-____ ____ ____ ____ Date of injury _____
Or
WC ID number _____

Date of report _____

Provider name _____

Provider address _____

Contact person _____ Telephone _____

Health care providers shall complete and submit the appropriate HCFA billing form and needed documentation to the employer. If the employer is covered by an insurer, the appropriate billing form and documentation is to be sent to the insurer. The LIBC-9 form and required accompanying documentation shall be submitted within 10 days of commencing treatment and at least once a month thereafter, as long as treatment continues. **If a provider does not submit the required medical reports in the prescribed format, the employer/insurer is not obligated to pay for such treatment until the required report is received by the employer/insurer.**

Documentation shall include (where pertinent) claimant's history, diagnosis, description of treatment and services rendered, physical findings and prognosis including whether or not there has been recovery enabling the claimant to return to work with or without limitations, and specific restrictions, if any, regarding return to work. Bills for follow-up visits should include progress/office notes to support the diagnosis and codes billed.

Providers may not charge for documentation supporting a claim for payment. Providers may charge their usual fee for special reports specifically requested by the employer/insurer. All patient information shall be submitted with the knowledge of the patient and must be maintained as confidential by the employer/insurer. The employer/insurer shall not be liable to pay for treatment until the required documents have been provided.

Listed on the reverse are guidelines for the completion of billing forms and submission of records.

BILLING FORM GUIDELINES:

Requests for payment of medical bills shall be made either on the HCFA Form 1500 or the UB92 Form, or any successor forms required by HCFA/CMS. Forms must be signed or typed with the name of the provider. Name and signature (if signature is used) must match.

Cost-based providers shall submit a detailed bill including service codes and rev codes consistent with the service codes and rev codes submitted to the Bureau of Workers' Compensation on the detailed charge master.

Until a health care provider submits bills on one of the forms specified above, employers/insurers are not required to pay for the treatment billed.

MEDICAL REPORT FORM GUIDELINES:

This form must be submitted within 10 days of initial treatment and monthly thereafter, and must be accompanied by documentation to support the billing.

Suggested supporting documentation:

Physicians — Office notes
Physical/Occupational therapists — Daily treatment records/notes with physician referral
Pharmacies — NCD#, amount dispensed, RX#
DME vendor — Medicare/HCPC code, certificate of medical necessity
Chiropractors — Treatment notes
Ambulance providers — Medicare codes, notes/reports
X-ray/MRI facilities — Reports
Lab Facilities — Test results
Anesthesia services — ASA code, base/time units, anesthesia record
Hospitals — Records from area providing the service (e.g. emergency, outpatient surgery...)
Inpatient hospital admissions — H&P, discharge summary, operative report (if applicable)
CORFs & Rehabilitation Centers — Daily treatment notes, including physician orders
Ambulatory surgery centers — Notes and reports

General for all providers: Use the most appropriate and specific HCFA/CMS coding on billing. When using miscellaneous codes, include detailed description of services.

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
toll-free inside PA TTY: 800.362.4228
local & outside PA TTY: 717.772.4991

Email
ra-li-bwc-helpline@pa.gov

STEP 2: TAKE ACTION

In Pennsylvania, workers' compensation carriers have thirty (30) days (plus 6 days for mailing) to respond to a billing. If the response is late, compensation carriers have to pay 10% per annum interest. They can respond in the following manners:

1. Payment;
2. Denial (If denied as not work related, contact attorney);
3. Filing a utilization review request; or
4. Silence.

FEE REVIEW (Amount of Payment)

If the carrier does not respond in the allotted amount of time or a payment amount is incorrect, the medical provider can then file a fee review. The Fee Schedule is on the Bureau of Workers' Compensation Website at http://www.dli.state.pa.us. Fee Review is the procedure to review the amount of the payment. This can be due to improper downcoding. If the carrier does not strictly comply with the downcoding procedures mandated by Section 127.207 of the regulations, the provider is entitled to reimbursement for the actual charges. A Fee Review can also be used to challenge the timeliness of payment as can a penalty petition.

Fee reviews must be filed within ninety (90) days of the original bill date OR within thirty (30) days after a denial or disputed payment is received, whichever occurs later. These time limits are strictly enforced and any fee review filed late will be dismissed.

The Department of Labor and Industry, Healthcare Services Review Section governs these reviews. **Only a medical provider can file a Fee Review.** A tutorial is available at the Bureau of Workers' Compensation website at www.dli.state.pa.us, Workers' Compensation Medical Treatment Information, Healthcare Services Form Tutorials. FAQS are also available at www.dli.state.pa.us, Workers' Compensation, FAQS, Healthcare Services Review FAQS. You may call the PA Workers' Compensation Hotline at (717) 772-4447 to obtain a Fee Review form for filing.

A sample copy of a Fee Review form is shown on the next page.

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

APPLICATION FOR FEE REVIEW PURSUANT TO SECTION 306 (F.1)

PATIENT/EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

DATE OF INJURY
MM DD YYYY

WCAIS CLAIM NUMBER

PATIENT/EMPLOYEE

First name
Last name
Date of birth
Address
Address
City/Town State ZIP
County
Telephone

PROVIDER

Name
Address
Address
City/Town State ZIP
Telephone
Federal tax ID number
MC Provider #NPI #
Specialty
Contact

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name
Address
Address
City/Town State ZIP
County
Telephone
Contact
NAIC code or Insurer code
(*Required: see BWC Website for NAIC or Insurer codes)
Insurer/TPA Claim #
FEIN

PROVIDER REPRESENTATIVE or CORRESPONDENCE ADDRESS (if Other than Above)

Name
Address
Address
City/Town State ZIP
Telephone

NOTICE: Section 306(f.1)(5) of the Workers' Compensation Act requires that the Application for Fee Review must be filed not more than 30 days following notification of a disputed treatment or 90 days following the original billing date of treatment, whichever is later.

EMPLOYER

Name
Address
Address
City/Town State ZIP
County
Telephone FEIN

INSTRUCTIONS:

If not filing electronically, this form must be used to request medical fee review pursuant to Section 306 (f.1)(5) of the Workers' Compensation Act. Your application will be returned and your request for review may not be considered until all requested documentation is provided per Sections 127.252(b) and 127.253 of the Rules and Regulations.

NOTE: If not filing electronically, send the original to: Bureau of Workers' Compensation, Medical Fee Review Section
1171 South Cameron Street, Harrisburg, PA 17104-2597

LIBC-507 REV 09-13 (Page 1)

PROOF OF SERVICE

I hereby certify that on ___ - ___ - ___, I served copies of the Application for Fee Review and the attached
MM DD YYYY

supporting documentation to _____
Insurer/Employer

_____
Street address

_____ via
City/Town State ZIP

_____
First class mail, overnight mail, etc.

_____ _____
Provider or representative's signature (Note: Request will be returned if not signed and dated) Provider or representative's name (Typed/Printed)

_____
Telephone

This is an Act 46 (firefighter cancer) claim

Is this Fee Review Request related to trauma? ☐ **Yes** ☐ **No**

Review being requested for: ☐ **Amount of payment** ☐ **Timeliness of payment** ☐ **Both**

Dates of service From			To			Date bill originally submitted to carrier:			Paid	Denied	Paid part/ Denied part	No response from insurer
MM	DD	YYYY	MM	DD	YYYY	MM	DD	YYYY	☐	☐	☐	☐
MM	DD	YYYY	MM	DD	YYYY	MM	DD	YYYY	☐	☐	☐	☐
MM	DD	YYYY	MM	DD	YYYY	MM	DD	YYYY	☐	☐	☐	☐
MM	DD	YYYY	MM	DD	YYYY	MM	DD	YYYY	☐	☐	☐	☐

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
toll-free inside PA TTY: 800.362.4228
local & outside PA TTY: 717.772.4991

Email
ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

LIBC-507 REV 09-13 (Page 2)

It is important to remember that to file a fee review you must fill out a LIBC-507 (see above sample form) and send it with a copy of the original bill, itemized bill, LIBC-9 (with original bill date) and medical records. Include a summary of why you are filing the review. Send a copy of the packet to the compensation carrier and keep a copy for your records. The original gets mailed to the Bureau of Workers Compensation. They will notify you of a decision within thirty (30) days of receipt of all necessary documents. The party unsatisfied with the fee review determination may file an appeal by filing a Request For Hearing To Contest Fee Review Determination (see Form on next page). The appeal must be filed within thirty (30) days of the administrative determination and will be assigned to a hearing officer who will issue a decision within ninety (90) days of the close of the evidentiary record. Further appeal will now be assigned to a workers' compensation judge.

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
WORKERS' COMPENSATION OFFICE OF ADJUDICATION

REQUEST FOR HEARING TO CONTEST FEE REVIEW DETERMINATION

PATIENT/EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

DATE OF INJURY (MM - DD - YYYY)

WCAIS CLAIM NUMBER

PROVIDER

Name
Address
Address
City/Town State ZIP
County
Telephone FEIN
Specialty
Contact

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name
Address
Address
City/Town State ZIP
County
Telephone FEIN
Contact
NAIC code or Insurer code
Insurer/TPA claim #

PATIENT/EMPLOYEE

First name
Last name
Date of birth
Address
Address
City/Town State ZIP

EMPLOYER

Name
Address
Address
City/Town State ZIP
Telephone FEIN

THIS REQUEST IS BEING FILED BY: ☐ **HEALTH CARE PROVIDER** ☐ **INSURER/EMPLOYER**

FEE REVIEW APPLICATION NUMBER(S) AND DATE OF FEE REVIEW DETERMINATIONS(S):

Application number: Determination date:
Application number: Determination date:
Application number: Determination date:

TO THE FEE REVIEW HEARING OFFICE:

I hereby request a de novo hearing by a fee review hearing officer under 34 Pa. Code §127.257 in the above-referenced Fee Review Application(s).

a. The following bills are disputed:

BILLING FORM	DATE OF BILL	SERVICE DATE	PROC/SVC CODE	AMOUNT BILLED

UTILIZATION REVIEW

(Reasonableness & Necessity)

If the workers' compensation carrier has filed a Utilization Review (UR), you should check to be certain that the UR was filed within thirty (30) days of the workers' compensation insurance carrier's receipt of the medical bill(s) being requested for review. It can be argued that the failure of the carrier to timely challenge a bill waives their right to challenge the reasonableness and necessity of the treatment.

When requested by the assigned utilization review organization (URO), you should do the following:

1. Timely provide your records to the URO!;
2. Insist on a telephone conference with the UR'er;
3. Encourage the patient to continue reasonable treatment;
   and
4. Encourage the patient to provide a written statement to the UR'er when requested.

A sample of a UR request form and instructions can be found on the next two pages.

INSTRUCTIONS FOR COMPLETING UTILIZATION REVIEW REQUEST

Pursuant to the provisions of the Workers' Compensation Act (Act) and 34 Pa. Code Chapter 127 Medical Cost Containment Regulations, Utilization Review (UR) of all treatment provided by a health care provider under the Act may be subject to UR at the request of an employee, employer or insurer. Persons requesting a UR must provide all information requested on the attached Utilization Review Request form. Please complete this form carefully and accurately and MAIL the original UR Request along with any attachments to:

Commonwealth of Pennsylvania Department of Labor & Industry
Bureau of Workers' Compensation Medical Treatment Review Section
1171 South Cameron Street, Room 310
Harrisburg, PA 17104-2597

Copies of the original UR Request along with any attachments must also be mailed to the employee, all providers under review, the insurer/employer and all counsel. **For any questions regarding the filing of the UR Request, please contact the Medical Treatment Review Section at (717) 772-1914.**

The UR Request must be filled out completely. All information is required. Please enter "NONE" where appropriate. Please Type or Print clearly.

1. **Request filed on behalf of:** Check the appropriate box.
2. **Employee Information:** Enter all requested information.
3. **Attorney for employee:** Enter all requested information.
4. **Employer information:** Enter all requested information.
5. **Insurer or self-insured employer's third party administrator (TPA):** Enter all requested information, including the 4 digit Bureau Code of the insurer or self-insured employer (available at www.dli.state.pa.us).
6. **Attorney for insurer/employer:** Enter all requested information.
7. **Provider(s) under review:** Enter the full name, complete address and telephone number of all providers who rendered or will render the treatment(s) or services(s) for which you are requesting UR. Remember that when the treatment or service to be reviewed is anesthesia incident to surgical procedures, diagnostic tests, prescriptions or durable medical equipment, the request for UR must identify the provider who made the referral, ordered or prescribed the treatment or service as the provider under review.

   Further, please note that you may only request review of individual providers (i.e., physician, chiropractors, etc.), and not facilities. While facilities are often "licensed" (i.e., hospitals, only the actual providers who treat patients may be reviewed. If the treatment which you wish to review constitutes a continuum of care, please identify all providers who rendered such treatment.

   Finally, if multiple providers rendered treatment under the direction or supervision of a provider with greater knowledge, education or responsibility for patient care, kindly identify both the individual providers and the directing/supervising provider.
8. **Treatment to be reviewed:** Specify ONLY the treatment or health care service to be reviewed (e.g. "Facet injections lumbar spine"), and identify the state date and end date of treatment(s) which you wish to submit to UR. If the end date is indeterminate, please enter "ongoing". If requesting a prospective review, simply state "prospective". Do not include any other information, such as billing issues, previous URs, or other comments which may influence a reviewer. Such comments will not be forwarded to a reviewer.
9. **Billing Dates for retrospective review:** A UR request must be filed within 30 days of the insurer/employer's receipt of the bill and medical report relating to the treatment under review. If you have not received a bill and/or medical report for the treatment under review or if this request is filed by the employee enter "none", otherwise, for each provider under review, enter the date upon which the insurer/employer received the bills and reports which represents the **start date** of treatment submitted for UR.
10. **Payment pending WCJ decision:** If payment for the treatment under review was withheld pending a decision on a claim or reinstatement petition, please so indicate provider(s), and enter the circulation date of the decision awarding benefits.
11. **Other treating providers:** On a separate sheet, enter the full name, license, specialty, complete address and valid telephone number of all other health care providers who rendered treatment or services for the work-related injury. Please do not include non-treating providers such as those who have performed independent medical examinations.
12. **Requesting party or representative:** Type or print your name, address and telephone number. You MUST sign the UR Request.
13. **Proof of Service:** Provide the date the UR Request was signed and mailed to all parties. If you amend or "re-file" this request, you must update the Proof of Service Date.

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

UTILIZATION REVIEW REQUEST

The UR Request must be filled out completely (follow instructions): ALL INFORMATION IS REQUIRED.

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER _____ - _____ - _____

DATE OF INJURY _____ - _____ - _____ (MM DD YYYY)

WCAIS CLAIM NUMBER _____

1. Filed on behalf of: ☐ Employee ☐ Insurer/Employer

2. **EMPLOYEE**
   - First name _____
   - Last name _____
   - Date of birth _____
   - Address _____
   - Address _____
   - City/Town _____ State ____ ZIP _____
   - County _____

3. **EMPLOYEE ATTORNEY**
   - Firm name _____
   - First name _____
   - Last name _____
   - Address _____
   - Address _____
   - City/Town _____ State ____ ZIP _____

4. **EMPLOYER**
   - Employer name _____
   - Address _____
   - Address _____
   - City/Town _____ State ____ ZIP _____

5. **INSURER OR SELF INSURED TPA**
   - NAIC code _____ or Bureau code _____ (Required: See BWC Website for Bureau codes)
   - Insurer/TPA name _____
   - Insurer claim # _____
   - Address _____
   - Address _____
   - City/Town _____ State ____ ZIP _____
   - Claim rep name _____

6. **INSURER/EMPLOYER ATTORNEY**
   - Firm name _____
   - First name _____
   - Last name _____
   - Address _____
   - Address _____
   - City/Town _____ State ____ ZIP _____

7-10 Provider Under Review/Treatment Information
Please see instructions

PROVIDER 1
First name _____ Last name _____
Office address _____
City _____ State _____ ZIP _____
Telephone _____ License/Specialty _____
Treatment to be reviewed:

Start/End date _____ WCJ Circulation date _____
Bill rec'd _____ None ☐ Report rec'd _____ None ☐

PROVIDER 2
First name _____ Last name _____
Office address _____
City _____ State _____ ZIP _____
Telephone _____ License/Specialty _____
Treatment to be reviewed:

Start/End date _____ WCJ Circulation date _____
Bill rec'd _____ None ☐ Report rec'd _____ None ☐

LIBC-601 REV 09-13 (Page 1)

PROVIDER 3
First name _____ Last name _____
Office address _____
City _____ State _____ ZIP _____
Telephone _____ License/Specialty _____
Treatment to be reviewed:

Start/End date _____ WCJ Circulation date _____
Bill rec'd _____ None ☐ Report rec'd _____ None ☐

PROVIDER 4
First name _____ Last name _____
Office address _____
City _____ State _____ ZIP _____
Telephone _____ License/Specialty _____
Treatment to be reviewed:

Start/End date _____ WCJ Circulation date _____
Bill rec'd _____ None ☐ Report rec'd _____ None ☐

PROVIDER 5
First name _____ Last name _____
Office address _____
City _____ State _____ ZIP _____
Telephone _____ License/Specialty _____
Treatment to be reviewed:

Start/End date _____ WCJ Circulation date _____
Bill rec'd _____ None ☐ Report rec'd _____ None ☐

(Pursuant to §127.404(b) the request for UR shall be filed within 30 days of receipt of the bill and report for the treatment at issue)

11. **Other Treating Providers:** If not filing electronically, please list any other treating providers for this claimant on additional sheet.
Include first and last name, license and specialty, full address and telephone number for each provider.

12. This is an Act 46 (firefighter cancer) claim

13. **Proof of Service:** I hereby certify that on this day I have mailed a copy of this request to all parties and their attorneys, if known, including the provider(s) under review. ANY FALSE STATEMENT CONTAINED IN THIS UTILIZATION REVIEW REQUEST MAY BE THE SUBJECT OF PROSECUTION UNDER ARTICLE XI OF THE ACT (RELATING TO INSURANCE FRAUD), OR 18 Pa. C.S. §4903 (RELATING TO FALSE SWEARING).

14. _____ Requesting Party or Representative's signature
_____ Requesting Party or Representative's name (typed/printed)
_____ Address
_____ City State ZIP
_____ Telephone number
_____ Email address
_____ Proof of Service date (MUST be updated if request is amended/re-filed)

NOTE: If not filing electronically, send the original to: Bureau of Workers' Compensation, Medical Treatment Review Section
1171 South Cameron Street, Harrisburg, PA 17104-2597

DO NOT attach deposition, medical records, IME reports or any other document not specifically requested to the UR Request Form. Any attachments not specifically requested will NOT be forwarded to the URO, and will NOT be returned. The Bureau will destroy/shred all attachments not requested.

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
toll-free inside PA TTY: 800.362.4228
local & outside PA TTY: 717.772.4991

Email
ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

LIBC-601 REV 09-13 (Page 2)

When the medical provider is requested to provide medical records to the URO, the URO shall provide reimbursement to the medical provider for copying costs at the rate specified by Medicare, along with payment for actual postage costs. Also, reproduction of radiographic films (x-rays, MRI's, CT Scans, etc.) shall be reimbursed at the usual and customary charge. *(See Section 127.463(a) and (b) of the Rules and Regulations governing actions under the Pennsylvania Workers' Compensation Act).*

If the UR determines that the treatment was unreasonable and/or unnecessary, contact the Attorney to file an appeal of the UR determination.

The appeal will be a brand "new" review of the treatment by a Workers' Compensation Judge. Also, most importantly, the workers' compensation insurance carrier will now have the BURDEN to prove that the treatment was unreasonable and unnecessary. The petition to review the UR determination will be assigned to a workers' compensation judge and will not be binding on the judge.

How long does the UR process take? When a UR request if filed, it takes about five (5) days for the Bureau to assign the petition to a URO. The URO will then collect the medical records and is prohibited from giving opinions on causation. A request for UR shall be deemed compete upon receipt of the medical records from the provider, or thirty (35) days after the notice of assignment of the review to a URO, whichever comes first. The provider will be given thirty (30) days to provide the records. **Failure of the medical provider to timely provide records will cause the treatment to be**

denied as not reasonable and necessary! Filing an appeal will not help. Once deemed completed, the URO has thirty (30) days to render their decision.

If a provider, an employee or an employer disagrees with the UR determination, they can file a request for review of the UR determination. The medical provider is not dependant on the injured worker filing an appeal. **The medical provider has standing to file the appeal.** We represent many treating doctors who hire us directly to file the appeal and to get their bills paid after a negative UR determination is issued.

A sample of the Petition to Review Utilization Review Determination can be found on the next page.

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
WORKERS' COMPENSATION OFFICE OF ADJUDICATION

PETITION FOR REVIEW OF UTILIZATION REVIEW DETERMINATION

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

DATE OF INJURY (MM DD YYYY)

WCAIS CLAIM NUMBER

If the insurer/employer, employee or provider disagrees with the determination rendered against it by the URO, the insurer/employer, employee or provider may file this petition to request that a Workers' Compensation Judge review the URO's determination.

EMPLOYEE

First name
Last name
Date of birth
Address
Address
City/Town State ZIP
County
Telephone

EMPLOYER

Name
Address
Address
City/Town State ZIP
County
Telephone FEIN

VS. INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name
Address
Address
City/Town State ZIP
County
Telephone FEIN
Insurer/TPA claim #

Utilization Review Number:
(FROM THE UTILIZATION REVIEW DETERMINATION FACE SHEET)

URO name
Address
Address
City/Town State ZIP

This request is filed by or on behalf of ■ Employee Insurer/Employer Health Care Provider

ATTORNEY FOR INSURER/EMPLOYEE (if known)

Name
Firm name
Address
Address
City/Town State ZIP
Telephone PA Attorney ID number

ATTORNEY FOR INSURER/EMPLOYER (if known)

Name
Firm name
Address
Address
City/Town State ZIP
Telephone PA Attorney ID number

I hereby request that this petition be assigned to a Workers' Compensation Judge for a hearing to determine the reasonableness or necessity of the treatment provided by or prescribed by the health care provider below:

PROVIDER UNDER REVIEW

First name _____

Last name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

ATTORNEY FOR PROVIDER (if known)

Name _____

Firm name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

Telephone _____ PA Attorney ID number _____

NOTE: The 'treatment to be reviewed' and the 'dates of treatment' can be obtained from the UR Request form.

Treatment to be reviewed: _____
(NOTE: DO NOT USE PROCEDURE CODES TO IDENTIFY TREATMENT TO BE REVIEWED)

Date(s) of treatment to be reviewed: ☐☐ - ☐☐ - ☐☐☐☐
MM DD YYYY

I hereby certify that on this day I have mailed a copy of this petition to all parties and their attorneys, if known, including the provider whose treatment is under review.

_____ _____
Requesting Party or Representative's signature Requesting Party or Representative's name (typed/printed)

Date ☐☐ - ☐☐ - ☐☐☐☐
MM DD YYYY

NOTICE: Petition will be returned if not signed and dated. Do not attach any documents to this petition. The Workers' Compensation Office of Adjudication will destroy all attachments and NOT forward them to the Workers' Compensation Judge and NOT return them to you.

NOTE: This petition must be filled out as fully as possible. If not filing electronically, the original must be sent to the Workers' Compensation Office of Adjudication, 1010 N 7th Street, Suite 202, Harrisburg, PA, 17102-1400. You must send a copy to all other parties, and on the attorneys of all other parties, if the attorneys are known. A proof of service must be attached. A proof of service is a signed statement signed by you verifying that you have sent a copy of the petition to all parties and their attorneys, if known. Questions regarding the completion of this form may be directed to Bureau of Workers' Compensation Claims Information Services.

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services	**Claims Information Services**	**Hearing Impaired**	**Email**
717.772.3702	toll-free inside PA: 800.482.2383 local & outside PA: 717.772.4447	toll-free inside PA TTY: 800.362.4228 local & outside PA TTY: 717.772.4991	ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

STEP 3 SILENCE

In the event that you receive NO RESPONSE to your original submission of your bill(s) to the workers' compensation insurance carrier or receive some excuse like *"the check is in the mail,"* then you should immediately contact the Attorney, who will review the matter to determine which of the following petitions should be filed:

1. FILE PROSPECTIVE UR: a quick and effective method of obtaining pre approval to guarantee payment of medical bills before the treatment is even rendered (don't believe the myth that there is no such thing as pre-approval in PA workers' comp);
2. FILE REVIEW PETITION for the payment of medical bills and an additional 10% interest on the unpaid bills;
3. FILE PENALTY PETITION requesting the additional payment of up to 50% penalties for the carrier's violation of the PA Workers' Compensation Act by delaying payment of medical bills.

A review petition is needed when the treatment is for a condition not clearly related to the injury accepted in the Notice of Compensation Payable. A Penalty Petition can be filed when payment is not made within thirty (30) days, or if payment is received well past the 30-day time frame. A Penalty Petition is most often used when workers' compensation ignores medical bills which are properly submitted and clearly related to the work injury. When filing a Penalty Petition, the medical bill must be clearly work-related, i.e., the medical documentation that was submitted with the

bill clearly identifies treatment to the injury/body part described on the Notice of Compensation Payable or Judge's Award.

Often times the mere filing of the Penalty Petition will be enough to effectuate payment from the workers' compensation insurance carrier. If not, a Judge will issue a Decision as to whether the workers' compensation insurance carrier failed to make timely payment and, if so, order payment to be made. The Judge can also order penalties to be paid by the workers' compensation insurance carrier, up to 50% of the outstanding medical bills plus 10% interest.

Lastly, if a bill is denied because it was within the first ninety (90) days of treatment and the doctor is not on the company posted list, call us to see if any of the many exceptions apply. Usually, one does and the compensation carrier must pay the bill. It is a myth that injured workers cannot treat with a doctor of their own choice during the first ninety days.

A sample of the REVIEW AND PENALTY petitions can be found on the next two pages.

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
WORKERS' COMPENSATION OFFICE OF ADJUDICATION

PETITION TO/FOR: (Check any that apply)

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

DATE OF INJURY (MM DD YYYY)

WCAIS CLAIM NUMBER

- ☐ Modify compensation benefits (Reduce/increase amount of workers' compensation)
- ☐ Penalties (For violation of the act, rules and regulations)
- ☐ Reinstate compensation benefits
- ☐ Review compensation benefits
- ☐ Review compensation benefits offset
- ☐ Review medical treatment and/or billing
- ☐ Seek approval of a compromise and release agreement (Ask judge to approve settlement)
- ☐ Set aside final receipt (Ask judge to set aside agreement to stop compensation)
- ☐ Suspend compensation benefits
- ☐ Terminate compensation: Based upon physician's affidavit, a special supersedeas hearing to be scheduled
- ☐ Terminate compensation benefits (Employee fully recovered without any disability)

This petition is filed on behalf of: ☐ Employee ☐ Employer/Insurer

EMPLOYEE

First name _____
Last name _____
Date of birth _____
If deceased - Dependent/Guardian/Personal Representative
First name _____
Last name _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____
County _____ Telephone _____

EMPLOYER

Name _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____
County _____
Telephone _____ FEIN _____

VS. INSURER, FUND or THIRD PARTY ADMINISTRATOR (if self-insured)

Name _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____
County _____
Telephone _____ FEIN _____
NAIC code _____ or Insurer code _____
Insurer/TPA claim # _____

INJURY INFORMATION

Provide the following information if Employer has accepted liability for this injury:

Part of body injured _____

Nature of injury

Accident/injury description narrative

Check if occupational disease ☐

"FUND" SHALL MEAN THE UNINSURED EMPLOYERS GUARANTY FUND, SUBSEQUENT INJURY FUND, SELF-INSURANCE GUARANTY FUND OR PRE-SELF-INSURANCE GUARANTY FUND.

TO YOUR HONORABLE JUDGE:

The above petitioner requests the workers' compensation judge to order the above action as of ☐☐ - ☐☐ - ☐☐☐☐ (MM DD YYYY) for the following reason(s).

- ☐ 1. Full recovery
- ☐ 2. Specific job offered
- ☐ 3. Work generally available
- ☐ 4. Able to return to unrestricted work
- ☐ 5. Has returned to work
- ☐ 6. Reasonable treatment refused
- ☐ 7. Resolution to specific loss
- ☐ 8. Incorrect description of injury
- ☐ 9. Incorrect average weekly wage
- ☐ 10. Medical bills unpaid
- ☐ 11. Medical bills not related
- ☐ 12. Worsening of condition
- ☐ 13. Injury causing decreased earning power
- ☐ 14. Section 314 order violated
- ☐ 15. Voluntary withdrawal from workforce
- ☐ 16. Violation of the act, rules and regulations
- ☐ 17. Subrogation, credit or offset for
  - ☐ UC ☐ Social Security ☐ Third party recovery
  - ☐ S&A ☐ Pension

18. Other

Compensation benefits

☐ being paid

☐ have been paid based on a:

☐ Notice of compensation payable dated ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY)

☐ Agreement dated ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY)

☐ Supplemental agreement dated ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY)

☐ Judge's order dated ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY)

☐ Board order dated ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY)

☐ Court order dated ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY)

This is an Act 46 (firefighter cancer) claim ☐

Is supersedeas being requested pursuant to Section 413(A.2)? ☐ Yes ☐ No
If yes, list reasons:

Average weekly wage $ ☐☐☐☐☐☐.☐☐

Applicable weekly total disability rate $ ☐☐☐☐☐☐.☐☐

Date of most recent payment ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY) Amount $ ☐☐☐☐☐☐.☐☐

PLEASE ENTER MY APPEARANCE FOR PETITIONER:

Attorney's name _____
PA attorney ID number _____
Firm name _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____
Telephone _____

COUNSEL FOR RESPONDENT (if known):

Attorney's name _____
PA attorney ID number _____
Firm name _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____
Telephone _____

_____
Petitioner or Representative's signature

Date of petition ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY)

_____
Petitioner or Representative's name (typed/printed)

Notice: This petition must be filed out as fully as possible. If not filing electronically, the original must be sent to the Workers' Compensation Office of Adjudication, 1010 N. Seventh St, Suite 202, Harrisburg, PA, 17102-1400. You must send a copy to all other parties, and to the attorneys of all other parties, if the attorneys are known. A proof-of-service must be attached. A proof-of-service is a signed statement signed by you verifying that you have sent a copy of the petition to all parties and their attorneys, if known. Questions regarding the completion of this form may be directed to Bureau of Workers' Compensation Claims Information Services.

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services	**Claims Information Services**	**Hearing Impaired**	**Email**
717.772.3702	toll-free inside PA: 800.482.2383 local & outside PA: 717.772.4447	toll-free inside PA TTY: 800.362.4228 local & outside PA TTY: 717.772.4991	ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

CONCLUSION

Payment of medical bills under the Pennsylvania Workers' Compensation system can be confusing and complicated. It is the desire of the attorneys at Calhoon & Associates that this guide book, the flow chart and the sample forms contained herein will assist you in an organized and simplified fashion to collect your medical bills in an almost hassle free fashion. However, hassles are bound to occur. When they do, feel free to contact the attorneys at Calhoon & Associates to assist you with this process and achieve the ultimate goal of providing medical care to your patients and getting your BILLS PAID. If you have any questions regarding workers' compensation feel free to call or to email Ron Calhoon at rcalhoon@pa-workers-comp-lawyers.com .

calhoon &associates, p.c.

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® 1

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You are in possession of this book because you want to make a difference in the lives of your work comp patients. You are seeking to lessen the friction with work comp patients over unpaid treatment bills and are seeking a higher percentage of payment for your work comp teatment bills with less frustration and delay for your medical billing staff.

It is our hope that you will take the time and care to read this book filled with valuable information to protect your work comp patients' rights. As you read this book and begin to weigh your options for your work comp patients, have your patient consider calling our office. At **Calhoon & Associates, P.C.,** we will discuss their case with you. We will then decide together the proper course of action to protect your patients' rights and help make sure all of their future medical needs are met without unneeded control, ineterference and intimidation by carriers who are not motivated by your patients' best interest. Your billing staff and your patients will THANK YOU for implementing the knowledge shared in these pages. For additional free answers to any questions contact us at 1-877-291-9675 or visit us online at www.workinjuryinpa.com.

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