
RULES AND REGULATIONS

TITLE 34. LABOR AND INDUSTRY

PART VIII. BUREAU OF WORKERS' COMPENSATION

CHAPTER 127. WORKERS' COMPENSATION MEDICAL COST CONTAINMENT

SUBCHAPTER A. PRELIMINARY PROVISIONS

§ 127.1. Purpose

This chapter implements those sections of the act that relate to payments made by insurers or self-insured employers for medical treatment and the review of medical treatment provided to employees with work-related injuries and illnesses.

§ 127.2. Computation of time

Unless otherwise provided, references to "days" in this chapter mean calendar days. For purposes of determining timeliness of filing and receipt of documents transmitted by mail, 3 days shall be presumed added to the prescribed period. If the last day for filing a document is a Saturday, Sunday or legal holiday, the time for filing shall be extended to the next business day. Transmittal by mail means by first-class mail.

§ 127.3. Definitions

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

ASC -- Ambulatory Surgery Center -- A center that operates exclusively for the purpose of furnishing outpatient surgical services to patients. These facilities are referred to by HCFA as ASCs and by the Department of Health as ASFs. For consistency with the application of Medicare regulations, these facilities are referred to in this chapter as ASCs.

ASF -- Ambulatory Surgical Facility -- An ASC.

Accredited speciality board -- A speciality board recognized by the American Board of Medical Specialties, the American Osteopathic Association or by the Chiropractic Council on Education.

Act -- The Workers' Compensation Act (77 P. S. §§ 1 -- 1041.4).

Act 44 -- The act of July 2, 1993 (P. L. 190, No. 44).

Actual charge -- The provider's usual and customary charge for a specific treatment, accommodation, product or service.

Acute care -- The inpatient and outpatient hospital services provided by a facility licensed by the Department of Health as a general or tertiary care hospital, other than a specialty hospital, such as rehabilitation and psychiatric provider.

Approved teaching program -- A hospital teaching program which is accredited in its field by the appropriate approving body to provide graduate medical education or paramedical education services, or both. Accreditation for medical education programs shall be as recognized by one of the following:

- (i) The Accreditation Council for Graduate Medical Education of the American Medical Association.

RULES AND REGULATIONS

- (ii) The Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association.
- (iii) The Council on Dental Education of the American Dental Association.
- (iv) The Council of Podiatric Medicine Education of the American Podiatric Association.
- (v) An appropriate approving body of paramedical educational and training programs.

Audited Medicare cost report -- The Medicare cost report, settled by the Medicare fiscal intermediary through the conduct of either a field audit or desk review resulting in the issuance of the Notice of Program Reimbursement.

Bureau -- The Bureau of Workers' Compensation of the Department.

Burn facility -- A facility which meets the service standards of the American Burn Association.

CCO -- Coordinated Care Organization -- An organization certified under Act 44 by the Secretary of Health for the purpose of providing medical services to injured employees.

CDT-1 -- The Current Dental Terminology, as defined by the American Dental Association.

CPT-4 -- The physician's "Current Procedural Terminology, Fourth Edition," as defined and published by the American Medical Association.

Capital related cost -- The health care provider's expense related to depreciation, interest, insurance and property taxes on fixed assets and moveable equipment.

Charge master -- A provider's listing of current charges for procedures and supplies utilized in the provider's billing process.

Commissioner -- The Insurance Commissioner of the Commonwealth.

DME -- Durable medical equipment -- The term includes iron lungs, oxygen tents, hospital beds and wheelchairs (which may include a power-operated vehicle that may be appropriately used as wheelchair) used in the patient's home or in an institution, whether furnished on a rental basis or purchased.

DRG -- Diagnostic related groups.

Department -- The Department of Labor and Industry of the Commonwealth.

Direct medical education cost -- The salaries and other expenses related to the provider's resident and intern graduate medical education approved teaching program. This amount includes the allocable overhead costs associated with the provider's maintenance and administration of the resident and intern programs.

Disproportionate share hospital -- A hospital providing acute care that serves a significantly disproportionate share of low-income patients.

Fully prospective -- Inpatient capital-related cost of an acute care provider included in the DRG payment based on a blend of hospital-specific data and Federal data and excluded from cost report settlements.

HCFA -- The Health Care Financing Administration.

RULES AND REGULATIONS

HCPCS -- HCFA Common Procedure Coding System -- The procedure codes and associated nomenclature consisting of numeric CPT-4 codes, and alpha-numeric codes, as developed both Nationally by HCFA and on a Statewide basis by local Medicare carriers.

Health care provider -- A person, corporation, facility or institution licensed, or otherwise authorized, by the Commonwealth to provide health care services, including physicians, coordinated care organizations, hospitals, health care facilities, dentists, nurses, optometrists, podiatrists, physical therapists, psychologists, chiropractors, or pharmacists, and officers, employees or agents of the person acting in the course and scope of employment or agency related to health care services.

Hold harmless -- Inpatient capital-related cost of an acute care provider which can either be included fully in the DRG payment or partially included in both the DRG and cost-reimbursed payment.

- (i) One hundred percent hold harmless means inpatient capital-related cost included fully in the DRG payment at 100% of the Federal capital rate.
- (ii) Blended hold harmless means inpatient capital-related cost included in the DRG payment for assets acquired after December 31, 1990, and cost-reimbursed for assets acquired before December 31, 1990.
- (iii) Capital-exceptional hospital means a provider receiving payment from Medicare based on cost because payments at either the fully prospective rate or the hold harmless rates are less than or equal to 70% of the provider's payments based on cost.

ICD-9-CM -- (ICD-9) The International Classification of Diseases -- Ninth Edition -- Clinical Modification.

Indirect medical education cost -- The expenses related to the use of additional ancillary services and consumption of provider resources related to the provision of a graduate medical education approved teaching program.

Insurer -- A workers' compensation insurance carrier, including the State Workmen's Insurance Fund, an employer who is authorized by the Department to self-insure its workers' compensation liability under section 305 of the act (77 P. S. § 501), or a group of employers authorized by the Department to act as a self-insurance fund under section 802 of the act (77 P. S. § 1036.2).

Interim rate notification -- The letter, from the Medicare intermediary to the provider, informing the provider of their interim payment rate and its effective date.

Life-threatening injury -- As defined by the American College of Surgeons' triage guidelines regarding use of trauma centers for the region where the services are provided.

Medicare carrier -- An organization with a contractual relationship with HCFA to process Medicare Part B claims.

Medicare intermediary -- An organization with a contractual relationship with HCFA to process Medicare Part A or Part B claims.

Medicare Part A -- Medicare hospital insurance benefits which pay providers for facility-based care, such as care provided in inpatient general and tertiary hospitals, specialty hospitals, home health agencies and skilled nursing facilities.

Medicare Part B -- Medicare supplementary medical insurance which pays providers for physician services, outpatient hospital services, durable medical equipment, physical therapy and other services.

RULES AND REGULATIONS

NPR -- Notice of program reimbursement -- The letter of notification from the Medicare intermediary to the provider regarding the final settlement of the Medicare cost report.

New provider -- A provider which began administering patient care after receiving initial licensure on or after August 31, 1993.

Notice of biweekly payment rates -- The letter of notification from the Medicare intermediary to the provider, informing the provider of their biweekly payment rate for direct medical education and paramedical education costs.

Notice of per resident amount -- The letter of notification from the Medicare intermediary to the provider, informing the provider of the annual payment amount per resident or intern full-time equivalent.

PRO -- Peer Review Organization -- An organization authorized by the Secretary for the purpose of determining the necessity or frequency of medical treatment administered to workers with work-related injuries.

Paramedical education cost -- The education cost related to providers' nongraduate medical education programs including nursing school programs, radiology and laboratory technology training programs and other allied health professional approved teaching programs.

Pass-through costs -- Medicare reimbursed costs to a hospital that "pass through" the prospective payment system and are not included in the DRG payments.

Provider -- A health care provider.

RCC -- Ratio of cost-to-charges -- The computed ratio using the Medicare cost report.

Secretary -- The Secretary of the Department.

Specialty hospital -- A health care facility licensed and approved by the Department of Health as a hospital providing either a comprehensive inpatient rehabilitation program or an acute psychiatric inpatient program.

Transition fee schedule -- The Medicare payment amounts as determined by the Medicare carrier, based on the transition rules requiring a blend of the full fee schedule (full implementation of the Resource Based Relative Value Scale, RBRVS) and the original provider fee schedule.

Trauma center -- A facility accredited by the Pennsylvania Trauma Systems Foundation under the Emergency Medical Services Act (35 P. S. §§ 6921 -- 6938).

UR -- Utilization Review.

URO -- Utilization Review Organization -- An organization authorized by the Secretary for the purpose of determining the reasonableness or necessity of medical treatment administered to workers with work-related injuries.

Unbundling -- The practice of separate billing for multiple service items or procedures instead of grouping the services into one charge item.

Urgent injury -- As defined by the American College of Surgeons' triage guidelines regarding use of trauma centers for the region where the services are provided.

RULES AND REGULATIONS

Usual and customary charge -- The charge most often made by providers of similar training, experience and licensure for a specific treatment, accommodation, product or service in the geographic area where the treatment, accommodation, product or service is provided.

Workers' Compensation judge -- As defined by section 401 of the act (77 P. S. § 701) (definition of "referee") and as appointed by the Secretary.

SUBCHAPTER B. MEDICAL FEES AND FEE REVIEW

CALCULATIONS

§ 127.101. Medical fee caps – Medicare

(a) Generally, medical fees for services rendered under the act shall be capped at 113% of the Medicare reimbursement rate applicable in this Commonwealth under the Medicare Program for comparable services rendered. The medical fees allowable under the act shall fluctuate with changes in the applicable Medicare reimbursement rates for services rendered prior to January 1, 1995. Thereafter, for services rendered on and after January 1, 1995, medical fees shall be updated only in accordance with §§ 127.151 -- 127.162 (relating to medical fee updates).

(b) Medicare coinsurance and deductibles may not be used to reduce the allowable fee under the act.

(c) If a provider's actual charges for services rendered are less than the maximum fee allowable under the act, the provider shall be paid only the actual charges for the services rendered.

(d) The Medicare reimbursement mechanisms that shall be used when calculating payments to providers under the act are set forth in §§ 127.103 -- 127.128.

(e) Medical fee caps based on Medicare will apply to all health care providers licensed in this Commonwealth who treat injured workers, regardless of whether the health care provider participates in the Medicare Program.

(f) An insurer may not make payment in excess of the medical fee caps, unless payment is made pursuant to a contract with a CCO certified by the Secretary of Health.

§ 127.102. Medical fee caps -- usual and customary charge

If a Medicare payment mechanism does not exist for a particular treatment, accommodation, product or service, the amount of the payment made to a health care provider shall be either 80% of the usual and customary charge for that treatment, accommodation, product or service in the geographic area where rendered, or the actual charge, whichever is lower.

§ 127.103. Outpatient providers subject to the Medicare fee schedule – generally

(a) When services are rendered by outpatient providers who are reimbursed under the Medicare Part B Program pursuant to the Medicare fee schedule, the payment under the act shall be calculated using the Medicare fee schedule as a basis. The fee schedule for determining payments shall be the transition fee schedule as determined by the Medicare carrier.

(b) The insurer shall pay the provider for the applicable Medicare procedure code even if the service in question is not a compensated service under the Medicare Program.

(c) If a Medicare allowance does not exist for a reported HCPCS code, or successor codes, the provider shall be paid either 80% of the usual and customary charge or the actual charge, whichever is lower.

RULES AND REGULATIONS

(d) When calculating payment for all services rendered on and before December 31, 1995, all rate increases, periodic adjustments and modifications incorporated into the Medicare Part B Fee Schedule shall be used. The effective date of these changes under Medicare shall also be the effective date of the fee changes under the act, as provided in § 127.151 (relating to medical fee updates prior to January 1, 1995 -- generally).

(e) Fee updates subsequent to December 31, 1994, shall be in accordance with §§ 127.152 and 127.153 (relating to medical fee updates on and after January 1, 1995 -- generally; and medical fee updates on and after January 1, 1995 -- outpatient providers, services and supplies subject to the Medicare fee schedule).

§ 127.104. Outpatient providers subject to the Medicare fee schedule – physicians

Payments to physicians for services rendered under the act shall be calculated by multiplying the Medicare Part B reimbursement for the services by 113%.

§ 127.105. Outpatient providers subject to the Medicare fee schedule – chiropractors

(a) Payments for services rendered by chiropractors shall be made for those services permitted by the Chiropractic Practice Act (63 P. S. §§ 625.101 -- 625.1106).

(b) Payments for spinal manipulation procedures by chiropractors shall be based on the Medicare fee schedule for HCPCS codes 98940 -- 98943, multiplied by 113%.

(c) Payments for physiological therapeutic procedures by chiropractors shall be based on the Medicare fee schedule for HCPCS codes 97010 -- 97799, multiplied by 113%.

(d) Payments shall be made for documented office visits and shall be based on the Medicare fee schedule for HCPCS codes 99201 -- 99205 and 99211 -- 99215, multiplied by 113%.

(e) Payment shall be made for an office visit provided on the same day as another procedure only when the office visit represents a significant and separately identifiable service performed in addition to the other procedure. The office visit shall be billed under the proper level HCPCS codes 99201 -- 99215, and shall require the use of the procedure code modifier "-25" (indicating a Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure).

§ 127.106. Outpatient providers subject to the Medicare fee schedule -- spinal manipulation performed by Doctors of Osteopathic Medicine

(a) Payments for spinal manipulation procedures by Doctors of Osteopathic Medicine shall be based on the Medicare fee schedule for HCPCS codes M0702 -- M0730 (through 1993) or HCPCS codes 98925 -- 98929 (1994 and thereafter), multiplied by 113%

(b) Payment shall be made for an office visit provided on the same day as a spinal manipulation only when the office visit represents a significant and separately identifiable service performed in addition to the manipulation. The office visit shall be billed under the proper level HCPCS codes 99201 -- 99215, and shall require the use of the procedure code modifier "-25" (indicating a Significant, Separately Identifiable Evaluation Management Service by the Same Physician on the Day of a Procedure).

(c) Payments for other services provided by Doctors of Osteopathic Medicine shall be calculated as provided for in § 127.104 (relating to outpatient providers subject to the Medicare fee schedule -- physicians).

§ 127.107. Outpatient providers subject to the Medicare fee schedule -- physical therapy centers and independent physical therapists

Payments to outpatient physical therapy centers and independent physical therapists not reimbursed in accordance with § 127.118 (relating to RCCs -- generally) shall be calculated by multiplying the Medicare Part B reimbursement for the services by 113%.

RULES AND REGULATIONS

§ 127.108. Durable medical equipment and home infusion therapy

Payments for durable medical equipment, home infusion therapy and the applicable HCPCS codes related to the infusion equipment, supplies, nutrients and drugs, shall be calculated by multiplying the Medicare Part B Fee Schedule reimbursement for the equipment or therapy by 113%.

§ 127.109. Supplies and services not covered by fee schedule

Payments for supplies provided over those included with the billed office visit shall be made at 80% of the provider's usual and customary charge when the provider supplies sufficient documentation to support the necessity of those supplies. Supplies included in the office visit code by Medicare may not be fragmented or unbundled in accordance with § 127.204 (relating to fragmenting or unbundling of charges by providers).

§ 127.110. Inpatient acute care providers – generally

(a) Payments to providers of inpatient acute care hospital services shall be based on the sum of the following:

- (1) One hundred thirteen percent of the DRG payment.
- (2) One hundred percent of payments that are reimbursed on the prospective payment system, as listed in subsection (b).
- (3) One hundred percent of pass-through costs.
- (4) One hundred percent of applicable cost outliers or 100% of applicable day outliers.

(b) In calculating the payment due, the following payments, which are reimbursed on a prospective payment basis by the Medicare Program, shall be multiplied by 100%:

- (1) The prospective portions of capital-related costs relating to payments to the following:
 - (i) Fully-prospective hospitals.
 - (ii) Hold-harmless hospitals reimbursed at 100% of the Federal rate (100% hold harmless).
 - (iii) Blended hold-harmless hospitals
- (2) Direct medical education costs.
- (3) Indirect medical education costs.

(c) In calculating the payment due, the following costs, which are reimbursed on a cost basis by the Medicare Program, shall be multiplied by 100%:

- (1) The cost portions of capital-related costs relating to the following:
 - (i) Blended hold-harmless hospitals.
 - (ii) Capital-exceptional hospitals.
- (2) Paramedical education costs.
- (3) Cost outliers or day outliers.

RULES AND REGULATIONS

§ 127.111. Inpatient acute care providers -- DRG payments

- (a) Payments to providers of inpatient hospital services, whose Medicare Program payments are based on DRGs, shall be calculated by multiplying the established DRG payment on the date of discharge by 113%.
- (b) For discharges on and before December 31, 1994, the DRG payments, using the Medicare DRG methodology, shall be based on the most recently published tables of payments, relative values, wage indices, geographic adjustment factors, rural and urban designations and other applicable Medicare payment adjustments published in the Federal Register. The effective date for these changes under the Medicare Program shall also be the effective date for the changes under the act.
- (c) If the amount of the DRG reimbursement changes during a patient's stay, the applicable reimbursement rate on the date of discharge shall be used to calculate payment under the act.
- (d) If a patient was admitted prior to August 31, 1993, the act's medical fee caps may not apply.

§ 127.112. Inpatient acute care providers -- capital-related costs

- (a) An additional payment shall be made to providers of inpatient hospital services for the capital-related costs reimbursed under the Medicare Part A Program.
- (b) Hospitals, which have a hospital-specific capital rate lower than the Federal capital rate (fully-prospective), shall be paid for capital-related costs as follows: the hospital's capital rate, as determined by the Medicare intermediary, shall be multiplied by the DRG relative weight on the date of discharge.
- (c) Hospitals, which have a hospital-specific capital rate equal to or higher than the Federal capital rate (hold-harmless), shall be paid for capital-related costs as follows:
 - (1) Hospitals paid at 100% of the Federal capital rate shall receive the Federal capital rate, as determined by the Medicare intermediary, multiplied by the DRG relative weight on the date of discharge.
 - (2) Hospitals paid at a rate greater than 100% of the Federal capital rate shall be paid on the basis of the most recent notice of interim payment rates as determined by the Medicare intermediary. Hospitals shall receive the new Federal capital rate multiplied by the DRG relative weight on the date of the discharge plus the old Federal capital rate as determined by the Medicare intermediary.
- (d) Capital-exceptional hospitals, or new hospitals within the first 2 years of participation in the Medicare Program, shall be paid for capital-related costs as follows: the most recent interim payment rate for capital-related costs, as determined by the Medicare intermediary, shall be added to the DRG payment on the date of discharge.

§ 127.113. Inpatient acute care providers -- medical education costs

- (a) Providers of inpatient hospital services shall receive an additional payment in recognition of the costs of medical education as provided pursuant to an approved teaching program and as reimbursed under the Medicare Program. For providers with an approved teaching program in place prior to January 1, 1995, the medical education add-on payment shall be based on the following calculations:
 - (1) Payments for direct medical education costs shall be based on figures from the latest audited Medicare cost report and calculated as follows: the medical education cost (Worksheet E, Part IV, Column 1, Line 18) shall be divided by total hospital DRG payments (Worksheet E, Part A, Column 1). This amount shall then be multiplied by the DRG payment on the date of discharge.

RULES AND REGULATIONS

(2) Payments for indirect medical education costs shall be calculated as follows: the add-on percentage, identified in the provider's latest Medicare interim rate notification, multiplied by the DRG payment on the date of discharge.

(3) Payments for paramedical education costs shall be calculated by determining the ratio of Medicare paramedical education costs to Medicare DRG payments. This ratio shall then be multiplied by the DRG payment on the date of discharge. The necessary ratio shall be computed as follows:

(i) If the most recently audited Medicare cost report is for a fiscal year beginning on or after October 1, 1991, and uses HCFA Form 2552-92, then the ratio shall be determined by taking the sum of Lines 14 and 15 on Worksheet E, Part A and dividing it by Line 1.

(ii) If the most recently audited Medicare cost report is for a fiscal year beginning before October 1, 1991, and uses HCFA Form 2552-89, then the ratio shall be determined by taking the sum of medical education costs from Worksheet D, Part I, Column 5, Line 101 and Worksheet D, Part II, Column 5, Line 101 and dividing the sum by total charges from Worksheet D, Part II, Column 7, Line 101; multiplying this amount by Medicare charges from Worksheet D, Part II, Column 9, Line 101; and dividing this amount by DRG payments from Worksheet E, Part A, Line 1.

(b) If a hospital loses its right to receive add-on payments for medical education costs under the Medicare Program, it shall also lose its right to receive the corresponding add-on payments for medical education costs under the act, commencing with services rendered on or after January 1 of the year succeeding the change in status. The hospital shall notify the Bureau in writing of this change in status on or before November 30 of the year in which the hospital has lost the right to receive a medical education add-on payment.

(c) On and after January 1, 1995, if a hospital begins receiving add-on payments for medical education costs under the Medicare Program, it shall also gain the right to receive add-on payments for medical education costs under the act, commencing with services rendered on or after January 1 of the year succeeding the change in status.

(1) The hospital shall notify the Bureau in writing of this change in status on or before November 30 of the year in which the hospital has gained the right to receive a medical education add-on payment. The notification shall include the following:

(i) Documentation that the medical education costs are incurred as the result of an approved teaching program, as accredited by the appropriate approving body.

(ii) The notice of per resident amount for direct medical education.

(iii) The interim rate notification for indirect medical education.

(iv) The notice of biweekly payment rates received from the Medicare Intermediary.

(v) A complete copy of the most recently audited Medicare cost report as of November 30 of the year in which the hospital gained the right to receive additional payments for medical education costs.

(2) If the hospital gained the right to receive a medical education add-on payment on or after January 1, 1995, the payment shall be based on the following calculations:

(i) Payments for direct medical education costs shall be based on the notice of biweekly payment amount. This amount shall be annualized, multiplied by the ratio of Part A reasonable cost to total reasonable cost from Worksheet E-3, Part IV, Line 15, and divided by total hospital DRG payments from the most recently audited Medicare cost report (Worksheet E, Part A, Column 1, Line 1). This amount shall then be multiplied by the DRG payment on the date of discharge.

RULES AND REGULATIONS

(ii) Payments for indirect medical education costs shall be calculated as follows: the add-on percentage, identified in the provider's most recent Medicare interim rate notification for the calendar year in which the approved teaching program commenced, multiplied by the DRG payment on the date of discharge.

(iii) Payments for paramedical education costs shall be based on the notice of biweekly payment amount. This amount shall be annualized, multiplied by the ratio of Part A reasonable cost to total reasonable costs from Worksheet E-3, Part IV, Line 15, and divided by total hospital DRG payments from the most recently audited Medicare cost report (Worksheet E, Part A, Column 1, Line 1). This amount shall be multiplied by the DRG payment on the date of discharge.

§ 127.114. Inpatient acute care providers – outliers

(a) Payments for cost outliers shall be based on the Medicare method for determining eligibility for additional payments as follows: the billed charges will be multiplied by the aggregate ratio of cost-to-charges obtained from the most recently audited Medicare cost report to determine the cost of the claim. This cost of claim shall be compared to the applicable Medicare cost threshold. Cost in excess of the threshold shall be multiplied by 80% to determine the additional cost outlier payment.

(b) Payments to acute care providers, when the length of stay exceeds the Medicare thresholds ("day outliers"), shall be determined by applying the Medicare methodology as follows: the DRG payment plus the capital payments shall be divided by the arithmetic mean of length of stay for that DRG as determined by HCFA to arrive at a per diem payment rate. This rate shall be multiplied by the number of actual patient days for the claim which are in excess of the outlier threshold as determined by HCFA and published in the Federal Register. The result is added to the DRG payment.

(c) When the calculations under both subsections (a) and (b) are greater than zero, the outlier payment shall be limited to the lesser of the cost outlier computed in accordance with subsection (a) or the day outlier computed in accordance with subsection (b).

§ 127.115. Inpatient acute care providers -- disproportionate-share hospitals

(a) An additional payment shall be made to providers of inpatient hospital services designated by the Medicare Program as disproportionate-share hospitals.

(b) Payments to disproportionate-share hospitals shall be calculated as follows: the add-on percentage identified in the provider's latest Medicare interim rate notification shall be multiplied by the DRG payment on the date of discharge and then multiplied by 113%.

(c) A provider requesting additional payments under the act based on its Medicare designation as a disproportionate-share hospital shall provide evidence of this designation to the insurer.

(d) If a hospital loses its right to receive additional payments as a disproportionate-share hospital under the Medicare Program prior to January 1, 1995, it shall also lose its right to receive additional payments under the act.

(e) Loss of the disproportionate-share designation on and after January 1, 1995, will not result in the loss of this designation for purposes of determining payments under the act.

(f) If a hospital gains the disproportionate-share designation on and after January 1, 1995, it will not be paid according to that designation under the act.

RULES AND REGULATIONS

§ 127.116. Inpatient acute care providers -- Medicare-dependent small rural hospitals, sole-community hospitals and Medicare-geographically reclassified hospitals

(a) Payments for Medicare-dependent small rural hospitals, sole-community hospitals and Medicare-geographically reclassified hospitals, shall be calculated as follows: the hospital's payment rate identified on the latest Medicare interim rate notice shall be multiplied by the DRG payment on the date of discharge and then multiplied by 113%.

(b) A provider requesting additional payments under the act based on one of the special designations in subsection (a) shall provide evidence of this Medicare designation to the insurer.

(c) If a hospital loses its designation as a Medicare-dependent small rural hospital, sole-community hospital or Medicare-geographically reclassified hospital under the Medicare Program prior to January 1, 1995, it shall also lose the designation and the right to receive additional payments under the act.

(d) Loss of one of the special designations in subsection (a) on and after January 1, 1995, will not result in the loss of the designation for purposes of determining payments under the act.

(e) If a hospital gains designation as a Medicare-dependent small rural hospital, sole-community hospital or Medicare-geographically reclassified hospital under the Medicare Program on and after January 1, 1995, it will not be paid according to that designation under the act.

§ 127.117. Outpatient acute care providers, specialty hospitals and other cost-reimbursed providers not subject to the Medicare fee schedule

The following services shall be paid on a cost-reimbursed basis for medical treatment rendered under Act 44:

(1) Outpatient services of general acute care providers and specialty hospitals reimbursed by Medicare using the HCFA Form 2552 or any successor form.

(2) Inpatient services provided in specialty hospitals and distinct part rehabilitation and psychiatric units of general acute care hospitals, which are exempt from the DRG reimbursement methodology and are reimbursed by Medicare using the HCFA Form 2552 or any successor form.

(3) Services provided in Comprehensive Outpatient Rehabilitation Facilities reimbursed by Medicare using the HCFA Form 2088 or any successor form.

(4) Services provided in outpatient therapy centers electing cost reimbursement for Medicare using the HCFA Form 2088 or any successor form.

§ 127.118. RCCs – generally

Payments for services listed in § 127.117 (relating to outpatient acute care providers, specialty hospitals and other cost reimbursed providers not subject to the Medicare fee schedule) shall be based on the provider's specific Medicare departmental RCC for the specific services or procedures performed. For treatment rendered on and before December 31, 1994, the provider's latest audited Medicare cost report, with an NPR date preceding the date of service, shall provide the basis for the RCC.

§ 127.119. Payments for services using RCCs

(a) Payments for services listed in § 127.117(1) (relating to outpatient acute care providers, specialty hospitals and other cost reimbursed providers not subject to the Medicare fee schedule) shall be calculated as follows: the provider charge shall be multiplied by the applicable RCC, which then shall be multiplied by 113%.

RULES AND REGULATIONS

(b) The RCC to be used for providers receiving payment for outpatient services under the RCC methodology shall be the same RCC used by the Medicare Program for determining reimbursement. For providers with audited cost reports using HCFA Form 2552-89 or earlier, Worksheet C, Part II, Column 10 is to be used. For providers with audited cost reports using HCFA Form 2552-92, Worksheet C, Part II, Column 8 is to be used.

(c) Payments for inpatient services listed in § 127.117(2) shall be calculated as follows:

(1) Inpatient routine services shall be reimbursed based on the inpatient routine cost per diem from the most recently audited Medicare cost report, HCFA Form 2552-89 or 2552-92, Worksheet D-1, Part II, Line 38. The routine cost per diem shall be updated by the TEFRA (Tax Equity and Fiscal Responsibility Act of 1982) target rate of increase as published by HCFA in the Federal Register. The applicable update shall be applied cumulatively based on the annual update factors published subsequent to the date of the audited cost report year end and prior to December 31, 1994.

(2) Inpatient ancillary services shall be reimbursed based on the provider charge multiplied by the applicable RCC, which then shall be multiplied by 113%.

(d) The RCC to be used for providers receiving payment for inpatient services under the RCC methodology shall be the same RCC used by the Medicare Program for determining reimbursement. For inpatient ancillary costs, using the most recently audited cost report (either the 2552-89 or the 2552-92 HCFA Forms) Worksheet C, Part I, Column 8 is to be used to obtain the RCC.

(e) Services related to clinical laboratory and provider based physicians shall be reimbursed in accordance with §§ 127.103 and 127.104 (relating to outpatient providers subject to the Medicare fee schedule -- generally; and outpatient providers subject to the Medicare fee schedule -- physicians).

§ 127.120. RCCs -- comprehensive outpatient rehabilitation facilities (CORFs) and outpatient physical therapy centers

(a) Except as noted in subsection (c), payments for services listed in § 127.117(3) and (4) (relating to outpatient acute care providers, specialty hospitals and other cost reimbursed providers not subject to the Medicare fee schedule) relating to CORFs and outpatient physical therapy centers, shall be calculated as follows: the provider's charge shall be multiplied by the applicable RCC which then shall be multiplied by 113%.

(b) In situations where the most recent audited Medicare cost report is for the fiscal year ending on or after April 30, 1993, and where the CORF or outpatient physical therapy center is reimbursed by Medicare using the HCFA Form 2088-92, the RCC to be used for the calculation in subsection (a) shall be the same RCC used by the Medicare Program for determining reimbursements at Worksheet C, Column 2.

(c) In situations where the most recent audited cost report is for the fiscal year ending before April 30, 1993, and where the CORF or outpatient physical therapy center is reimbursed by Medicare using the HCFA 2088 form, the payment method to be used shall be as follows:

(1) For providers whose basis of Medicare apportionment is gross charges, the RCC shall be developed by dividing the total departmental cost for each therapy department on line 4 of Schedule C and by the total charges for each therapy department on line 1 of Schedule C. Payments then shall be calculated in accordance with subsection (a).

(2) For providers whose basis of Medicare apportionment is therapy visits, the payment rate shall be based on the average cost per visit, developed by dividing the total departmental cost for each therapy department on line 4 of Schedule C by the total visits for each therapy department on line 1 of Schedule C. Payments for services shall then be calculated as follows: the average cost per visit shall be multiplied by the billed number of visits and then multiplied by 113%.

RULES AND REGULATIONS

(3) For providers whose basis of Medicare apportionment is weighted units, the payment rate shall be based on the average cost per weighted unit, developed by dividing the total departmental cost for each therapy department on line 4 of Schedule C by the total weighted units for each therapy department on line 1 of Schedule C. Payments for services shall then be calculated as follows: the average cost per weighted unit shall be multiplied by the billed units and then multiplied by 113%.

§ 127.121. Cost-reimbursed providers -- medical education costs

(a) Cost-reimbursed providers shall receive an additional payment in recognition of the costs of medical education as provided pursuant to an approved teaching program, and as reimbursed under the Medicare Program. For providers with an approved teaching program in place prior to January 1, 1995, the medical education add-on payment shall be calculated as follows, using figures from the most recently audited Medicare cost report.

(1) The hospital's outpatient medical education to Medicare outpatient cost ratio shall be determined by taking the outpatient medical education cost from Supplemental Worksheet E-3, Part IV, Column 1, Line 19, and dividing it by the Medicare outpatient cost from Supplemental Worksheet E-3, Part IV, Column 1, Line 13.03. This ratio shall then be multiplied by the provider's charges, multiplied by the applicable RCC.

(2) The hospital's inpatient medical education to Medicare inpatient cost ratio shall be determined by taking the inpatient medical education cost from Supplemental Worksheet E-3, Part IV, Column 1, Line 18, and dividing it by the Medicare inpatient cost from Supplemental Worksheet E-3, Part IV, Column 1, Line 12.05. This ratio shall then be multiplied by the provider's charges, multiplied by the applicable RCC.

(3) Payments for the cost of indirect medical education are included in the RCC payment and are not to be calculated as a separate item.

(b) If the cost-reimbursed provider loses its right to receive add-on payments for medical education costs under the Medicare Program, it shall also lost its right to receive add-on payments for medical education costs under the act, commencing with services rendered on or after January 1 of the year succeeding the change in status. The provider shall notify the Bureau in writing of this change in status on or before November 30 of the year in which the provider has lost the right to receive a medical education add-on payment.

(c) On and after January 1, 1995, if the cost-reimbursed provider begins receiving add-on payments for medical education costs under the Medicare Program, it shall also gain the right to receive add-on payments for medical education costs under the act, commencing with services rendered on or after January 1 of the year succeeding the change in status.

(1) The provider shall notify the Bureau in writing of this change on or before November 30 of the year in which the provider has gained the right to receive a medical education add-on payment. The notification shall include the following:

(i) Documentation that the medical education costs are incurred as the result of an approved teaching program, as accredited by the appropriate approving body.

(ii) The notice of per resident amount.

(iii) The notice of biweekly payment rates received from the Medicare intermediary.

(iv) A complete copy of the most recently audited Medicare cost report as of November 30 of the year in which the provider gained the right to receive additional payments for medical education costs.

RULES AND REGULATIONS

(2) If the provider gained the right to receive a medical education add-on payment on or after January 1, 1995, the payment shall be based on the notice of biweekly payment amount. This amount shall be annualized and divided by the sum of the hospitals' inpatient and outpatient cost from Supplemental Worksheet E-3, Part IV, Column 1, Line 12.05 and Line 13.03. This ratio shall then be multiplied by the provider's charges, multiplied by the applicable RCC, multiplied by applicable updates and added to the charge master payment rates.

§ 127.122. Skilled nursing facilities

Payments to providers of skilled nursing care who file Medicare cost reporting forms HCFA 2540 (freestanding facilities) or HCFA 2552 (hospital based facilities), or any successor forms, shall be calculated as follows: the most recent Medicare interim per diem rate shall be multiplied by the number of patient days and then multiplied by 113%.

§ 127.123. Hospital-based and freestanding home health care providers

Payments to providers of home health care who file an HCFA Form 1728 (freestanding facilities) or an HCFA Form 2552 (hospital-based facilities), or any successor forms, shall be calculated as follows: the per visit limitation as determined by the Medicare Program multiplied by 113%. If the usual and customary charge per visit is lower than this calculation, then payment shall be limited to the usual and customary charge per visit. Payment at 113% of the Medicare limit shall represent payment for the entire service including all medical supplies and other items subject to cost reimbursement by the Medicare Program.

§ 127.124. Outpatient and end-stage renal dialysis payment

(a) Payments to providers of outpatient and end-stage renal dialysis shall be calculated as follows: the Medicare composite rate, per treatment, shall be multiplied by 113%.

(b) Hospital outpatient ancillary services paid outside of the Medicare composite rate shall be reimbursed in accordance with § 127.119 (relating to payments for services using RCCs).

§ 127.125. ASCs

Payments to providers of outpatient surgery in an ASC, shall be based on the ASC payment groups defined by HCFA, and shall include the Medicare list of covered services and related classifications in these groups. This payment amount shall be multiplied by 113%. For surgical procedures not included in the Medicare list of covered services, payments shall be based on 80% of the usual and customary charge.

§ 127.126. New providers

(a) New providers who are receiving payments in accordance with § 127.103 or § 127.120 (relating to outpatient providers subject to the Medicare fee schedule -- generally; and RCCs -- comprehensive outpatient rehabilitation facilities (CORFs) and outpatient physical therapy centers) shall bill and receive payments beginning with the treatment of their first workers' compensation patient.

(b) New providers who are receiving payments in accordance with § 127.117 (relating to outpatient acute care providers, speciality hospitals and other cost-reimbursed providers not subject to the Medicare fee schedule) shall receive payments calculated as follows:

(1) Commencing with the date the provider begins treating its first patient until the completion and filing of the first Medicare cost report, payment shall be based on the aggregate RCC using the most recent Medicare interim rate notification.

RULES AND REGULATIONS

(2) Within 30 days of the filing of the first cost report a new provider shall submit to the Bureau a copy of the detailed charge master in effect at the conclusion of the first cost report year and a copy of the filed cost report. Upon receipt of the filed cost report, payments shall be made in accordance with § 127.119 (relating to payments for services using RCCs), using the filed RCCs. The detailed charge master will be frozen in accordance with § 127.155 (relating to medical fee updates on and after January 1, 1995 -- outpatient acute care providers, specialty hospitals and other cost reimbursed providers).

(3) Upon receipt of the NPR, payments shall be made in accordance with § 127.119.

(c) A new provider shall submit a copy of the audited Medicare cost report and NPR to the Bureau within 30 days of receipt by the provider.

§ 127.127. Mergers and acquisitions

(a) When a merger, acquisition or change in ownership results in the elimination of the assets of a merged or acquired entity, and consolidation of the assets into the surviving entity, payments shall be determined by reference to the relevant cost reports and other relevant data of the surviving entity, except as noted in subsection (b).

(b) If services were provided at the merged or acquired provider that were not provided at the surviving provider (prior to merger or acquisition) and therefore were not reported as a cost center on its most recently audited Medicare cost report, the per diem rates and RCCs to be used for determining payment for these services shall be obtained from the most recently audited cost report of the merged or acquired provider.

§ 127.128. Trauma centers and burn facilities -- exemption from fee caps

(a) Acute care provided in a trauma center or a burn facility is exempt from the medical fee caps, and shall be paid based on 100% of usual and customary charges if the following apply:

(1) The patient has an immediately life-threatening injury or urgent injury.

(2) Services are provided in an acute care facility that is one of the following:

(i) A level I or level II trauma center, accredited by the Pennsylvania Trauma Systems Foundation under the Emergency Medical Services Act (35 P. S. §§ 6921 -- 6938).

(ii) A burn facility which meets the service standards of the American Burn Association.

(b) Basic or advanced life support services, as defined and licensed under the Emergency Medical Services Act, provided in the transport of patients to trauma centers or burn facilities under subsection (a) are also exempt from the medical fee caps, and shall be paid based on 100% of usual and customary charges.

(c) If the patient is initially transported to the trauma center or burn facility in accordance with the American College of Surgeons' (ACS) triage guidelines, payment for transportation to the trauma center or burn facility, and payments for the full course of acute care services by all trauma center or burn facility personnel, and all individuals authorized to provide patient care in the trauma center or burn facility, shall be at the provider's usual and customary charge for the treatment and services rendered.

(d) The determination of whether a patient's initial and presenting condition meets the definition of a life-threatening or urgent injury shall be based upon the information available at the time of the initial assessment of the patient. A decision by ambulance personnel that an injury is life-threatening or urgent shall be presumptive of the reasonableness and necessity of the transport to a trauma center or burn facility, unless there is clear evidence of violation of the ACS triage guidelines.

RULES AND REGULATIONS

- (e) The exemptions in subsections (a) and (b) also apply when a patient has been transferred to a trauma center or burn facility pursuant to the ACS High-Risk Criteria for Consideration of Early Transfer.
- (f) The exemptions also apply, and continue for the full course of treatment, when a patient is transferred from one trauma center or burn facility to another trauma center or burn facility.
- (g) The medical fee cap exemptions may not continue to apply for payments for acute care treatment and services for life-threatening or urgent injuries following a transfer from a trauma center or burn facility to any other provider.
- (h) Trauma centers and burn facilities shall provide the Bureau with evidence of their status including changes in status. An insurer may request evidence that an acute care facility's status as a trauma center or burn facility, was in effect on the dates services were rendered to an injured worker.

§ 127.129. Out-of-State medical treatment

- (a) When injured employees are treated outside of this Commonwealth by providers who are licensed by the Commonwealth to provide health care services, the applicable medical fee cap shall be as follows:
 - (1) If the provider is both licensed by and has a place of business within this Commonwealth, the medical fees shall be capped based on the Medicare reimbursement rate applicable under the Medicare Program for services rendered at the provider's primary place of business in this Commonwealth, subject to § 127.152 (relating to medical fee updates on and after January 1, 1995 -- generally).
 - (2) If the provider is licensed by the Commonwealth to provide health care services but does not have a place of business within this Commonwealth, medical fees shall be capped based on the Medicare reimbursement rate applicable in Harrisburg, Pennsylvania, under the Medicare Program for the services rendered subject to § 127.152.
- (b) When injured employees are treated outside of this Commonwealth by providers who are not licensed by the Commonwealth to provide health care services, medical fees shall be capped based on the Medicare reimbursement rate applicable in Harrisburg, Pennsylvania, under the Medicare Program for the services rendered subject to § 127.152.

§ 127.130. Special reports

- (a) Payments shall be made for special reports (CPT code 99080) only if these reports are specifically requested by the insurer. Office notes and other documentation which are necessary to support provider codes billed may not be considered special reports.
- (b) Payments for special reports shall be at 80% of the provider's usual and customary charge.
- (c) The Bureau-prescribed report required by § 127.203 (relating to medical bills -- submission of medical reports) may not be considered a special report that is chargeable under this section.

§ 127.131. Payments for prescription drugs and pharmaceuticals – generally

- (a) Payments for prescription drugs and professional pharmaceutical services shall be limited to 110% of the average wholesale price (AWP) of the product.
- (b) Pharmacists and insurers may reach agreements on which Nationally recognized schedule shall be used to define the AWP of prescription drugs. The Bureau in resolving payment disputes, may use any of the Nationally recognized schedules to determine the AWP of prescription drugs. The Bureau will provide information by an annual notice in the Pennsylvania Bulletin as to which of the Nationally recognized schedules it is using to determine the AWP of prescription drugs.

RULES AND REGULATIONS

(c) Pharmacists may not bill, or otherwise hold the employe liable, for the difference between the actual charge for the prescription drugs and pharmaceutical services and 110% of the AWP of the product.

§ 127.132. Payments for prescription drugs and pharmaceuticals -- direct payment

(a) Insurers may enter into agreements with pharmacists authorizing pharmacists to bill the cost of prescription drugs directly to the insurer.

(b) When agreements are reached under subsection (a), insurers shall promptly notify injured employes of the names and locations of pharmacists who have agreed to directly bill and accept payment from the insurer for prescription drugs. However, insurers may not require employes to fill prescriptions at the designated pharmacies.

§ 127.133. Payments for prescription drugs and pharmaceuticals -- effect of denial of coverage by insurers

If an injured employe pays more than 110% of the average wholesale price of a prescription drug because the insurer initially does not accept liability for the claim under the act, or denies liability to pay for the prescription, the insurer shall reimburse the injured employe for the actual cost of the prescription drugs, once liability has been admitted or determined.

§ 127.134. Payments for prescription drugs and pharmaceuticals -- ancillary services of health care providers

A pharmacy or pharmacist owned or employed by a health care provider, which is recognized and reimbursed as an ancillary service by Medicare, and which dispenses prescription drugs to individuals during the course of treatment in the provider's facility, shall receive payment under the applicable Medicare reimbursement mechanism multiplied by 113%.

§ 127.135. Payments for prescription drugs and pharmaceuticals -- drugs dispensed at a physician's office

(a) When a prescription is filled at a physician's office, payment for the prescription drug shall be limited to 110% of the average wholesale price of the product.

(b) Physicians may not bill, or otherwise hold the employe liable, for the difference between the actual charge for the prescription drug and 110% of the AWP of the product.

MEDICAL FEE UPDATES

§ 127.151. Medical fee updates prior to January 1, 1995 – generally

(a) Changes in Medicare reimbursement rates prior to January 1, 1995, shall be reflected in calculations of payments to providers under the act.

(b) The effective date for these rate changes under the Medicare Program shall also be the effective date for the fee changes under the act. The new rates shall apply to all treatment and services provided on and after the effective date of the rate change.

§ 127.152. Medical fee updates on and after January 1, 1995 – generally

(a) Changes in Medicare reimbursement rates on and after January 1, 1995, may not be included in calculations of payments to providers under Act 44.

(b) Medical fee updates on and after January 1, 1995, shall be calculated based on the percentage changes in the Statewide average weekly wage, as published annually by the Department in the Pennsylvania Bulletin. These updates shall be effective on January 1 of each year, and they shall be cumulative.

RULES AND REGULATIONS

§ 127.153. Medical fee updates on and after January 1, 1995 -- outpatient providers, services and supplies subject to the Medicare fee schedule

(a) On and after January 1, 1995, outpatient providers whose payments under the act are based on the Medicare fee schedule under §§ 127.103 -- 127.108 shall be paid as follows: the amount of payment authorized shall be frozen on December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.

(b) On and after January 1, 1995, adjustments and modifications by HCFA relating to a change in description or renumbering of any HCPCS code will be incorporated into the basis for determining the amount of payment as frozen in subsection (a) for services rendered under the act.

(c) On and after January 1, 1995, payment rates under the act for new HCPCS codes will be based on the rates allowed in the Medicare fee schedule on the effective date of the new codes. These payment rates shall be frozen immediately, and thereafter updated annually by the percentage change in the Statewide average weekly wage.

§ 127.154. Medical fee updates on and after January 1, 1995 -- inpatient acute care providers subject to DRGs plus add-on payments

(a) On and after January 1, 1995, inpatient acute care providers, whose payments under the act are based on DRGs plus add-ons under §§ 127.110 -- 127.116 shall be paid as follows: the amount of payment authorized and based on the DRG shall be frozen on December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.

(b) The DRG grouper in effect for Medicare DRG payments as of December 31, 1994, shall remain in effect and be frozen for purposes of determining payments under the act. Additions, deletions or modifications to the ICD-9 codes used to determine the DRG shall be mapped to the appropriate DRG within the frozen grouper.

(c) The relative values of DRGs in effect on December 31, 1994, shall be frozen for purposes of calculating payments under the act. The introduction of modified or new DRGs, on and after January 1, 1995, may not be utilized for purposes of calculating payments under the act.

(d) On and after January 1, 1995, add-on payments based on capital-related costs as set forth in § 127.112 (relating to inpatient acute care providers -- capital-related costs) shall be frozen at the rates in effect on December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.

(e) On and after January 1, 1995, add-on payments based on medical education costs as set forth in § 127.113 (relating to inpatient acute care providers -- medical education costs) shall be frozen based on the calculations made using the Medicare cost report and Medicare interim rate notification in effect on December 31, 1994. These frozen rates shall be applied to the updated DRG rates in subsection (a).

(1) Hospitals which lose the right to receive add-on payments based on medical education costs under the Medicare Program on and after January 1, 1995, shall also lose their right to receive these payments under the act as set forth in § 127.113. Commencing with services rendered on or after January 1 of the year succeeding the change in status, the add-on payment that has been computed and included in the Medicare fee cap as frozen on December 31, 1994, shall be eliminated from the calculation of the reimbursement.

(2) Hospitals which gain the right to receive add-on payments based on medical education costs under the Medicare Program on and after January 1, 1995, shall receive payments based on the rates calculated in § 127.113(c). These payments shall be frozen immediately, and thereafter shall be applied to the updated DRG rates in subsection (a).

RULES AND REGULATIONS

(f) On and after January 1, 1995, add-on payments based on cost outliers as set forth in § 127.114 (relating to inpatient acute care providers -- outliers) shall continue to float with changes made pursuant to the Medicare Program, using the most recently audited cost reports to calculate the additional payment. These payments may not receive fee updates based on changes in the Statewide average weekly wage.

(g) On and after January 1, 1995, add-on payments based on day outliers as set forth in § 127.114 shall be frozen based on the arithmetic and geometric mean length of stay in effect for discharges on December 31, 1994. These frozen rates shall be applied to the updated DRG rates in subsection (a).

(h) On and after January 1, 1995, add-on payments based on the designation under the Medicare Program as a disproportionate share hospital, shall be frozen based on the designation and calculation in effect on December 31, 1994. These frozen rates shall be applied to the updated DRG rates in subsection (a).

(i) On and after January 1, 1995, payments based on designations under the Medicare Program as a Medicare-dependent small rural hospital, sole-community hospital and Medicare-geographically reclassified hospital shall be frozen based on the designations and calculations in effect on December 31, 1994. These rates shall be updated annually by the percentage change in the Statewide average weekly wage.

§ 127.155. Medical fee updates on and after January 1, 1995 -- outpatient acute care providers, specialty hospitals and other cost-reimbursed providers

(a) As of January 1, 1995, providers identified in § 127.117 (relating to outpatient acute care providers, specialty hospitals and other cost-reimbursed providers not subject to the Medicare fee schedule) shall be paid as follows: as of December 31, 1994, the provider's actual charge by procedure as determined from the detailed charge master, shall be multiplied by the ratio of cost-to-charges, based on the most recently audited Medicare cost report. Except as noted in subsection (b), this amount shall be frozen for purposes of calculating payments under the act and updated annually by the percentage change in the Statewide average weekly wage.

(b) Subsection (a) does not apply in situations where the charge master does not contain unique charges for each item of pharmacy, but instead actual charges are based on algorithms or other mathematical calculations to compute the charge. For purposes of effectuating the freeze, the providers' RCC for pharmacy (drug charges to patients) shall be frozen based on the last audited Medicare cost report as of December 31, 1994. On and after January 1, 1995, the providers' actual charges shall be multiplied by the frozen RCC and then by 113% to determine reimbursements. These payments may not receive fee updates based on changes in the Statewide average weekly wage.

(c) For purposes of effectuating the freeze in reimbursements as provided in subsection (a), the Bureau will calculate the appropriate fee caps for cost-reimbursed providers who are identified in § 127.117. In order to accomplish this task, the Bureau will utilize information obtained from a complete copy of the provider's detailed charge master by procedure/service codes, HCPCS codes and by applicable Medicare revenue code with rates effective as of September 1, 1994, and RCCs from the most recently audited Medicare cost report in effect as of December 31, 1994.

(1) The charge information obtained for purposes of subsection (c) calculations, will remain in the possession of the Bureau. Unless the Bureau obtains the written permission of the provider, the charge information will not be released to anyone other than an authorized representative of the provider.

(2) The Bureau will provide the calculated fees to insurers.

(d) Cost-reimbursed providers adding new services requiring the addition of new procedure codes within previously reported Medicare revenue codes and frozen RCCs shall receive payment based on the charge associated with the new code multiplied by the frozen RCC.

RULES AND REGULATIONS

(e) Cost-reimbursed providers adding new services requiring the addition of new procedure codes outside of the previously reported Medicare revenue codes and frozen RCC, shall receive payment as follows:

(1) Prior to the completion of the audited cost report which includes the new services, payment shall be based on 80% of the provider's usual and customary charge.

(2) Upon completion of the first audited cost report which includes the new services, payment shall be based on the charge associated with the new code multiplied by the audited RCC including those charges. Payment rates shall be frozen immediately and updated annually by the percentage change in the Statewide average weekly wage.

(f) On and after January 1, 1995, add-on payments based on medical education costs as set forth in § 127.121 (relating to cost-reimbursed providers -- medical education costs) shall be frozen based on the calculations made using the Medicare Cost Report. These rates shall be updated annually by the percentage change in the Statewide average weekly wage.

(1) Cost-reimbursed providers that lose their right to receive add-on payments based on medical education costs under the Medicare Program on and after January 1, 1995, shall also lose their right to receive these payments under the act as set forth in § 127.121. Commencing with services rendered on or after January 1 of the year succeeding the change in status, the add-on payment that has been computed and included in the Medicare fee cap as frozen on December 31, 1994, including annual updates attributable to those medical education add-on payments, shall be eliminated from the calculation of the reimbursement. The new reimbursement rate shall be frozen immediately and shall be updated annually by the percentage change in the Statewide average weekly wage.

(2) Cost-reimbursed providers that gain the right to receive add-on payments based on medical education costs under the Medicare Program on and after January 1, 1995, shall receive payments based on the rates calculated in § 127.121. These rates shall be frozen immediately and shall be updated annually by the percentage change in the Statewide average weekly wage.

(g) On and after January 1, 1995, payments to comprehensive outpatient rehabilitation facilities, as set out in § 127.120 (relating to RCCs -- comprehensive outpatient rehabilitation facilities (CORFs) and outpatient physical therapy centers), shall be frozen and updated as follows:

(1) For providers whose basis of Medicare apportionment is gross charges, payment rates will be frozen on December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.

(2) For providers whose basis of Medicare apportionment is visits or weighted units, the computed payment rate as of December 31, 1994, shall be frozen and updated annually by the percentage change in the Statewide average weekly wage.

§ 127.156. Medical fee updates on and after January 1, 1995 -- skilled nursing facilities

On and after January 1, 1995, payments to skilled nursing facilities shall be as follows: the amount of the payment set forth in § 127.122 (relating to skilled nursing facilities) shall be frozen on December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.

§ 127.157. Medical fee updates on and after January 1, 1995 -- home health care providers

On and after January 1, 1995, payments to home health care providers shall be as follows: the amount of the payment set forth in § 127.123 (relating to hospital-based and freestanding home health care providers) shall be frozen on December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.

RULES AND REGULATIONS

§ 127.158. Medical fee updates on and after January 1, 1995 -- outpatient and end-stage renal dialysis

On and after January 1, 1995, payments to providers of outpatient and end-stage renal dialysis shall be as follows: the amount of the payment set forth in § 127.124 (relating to outpatient and end-stage renal dialysis payments) shall be frozen on December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.

§ 127.159. Medical fee updates on and after January 1, 1995 -- ASCs

On and after January 1, 1995, payments to providers of outpatient surgery in ASCs shall be as follows: the amount of the payment in § 127.125 (relating to ASCs) shall be frozen on December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.

§ 127.160. Medical fee updates on and after January 1, 1995 -- trauma centers and burn facilities

Trauma centers and burn facilities shall continue to receive their usual and customary charges on and after January 1, 1995, in accordance with § 127.128 (relating to trauma centers and burn facilities -- exemption from fee caps).

§ 127.161. Medical fee updates on and after January 1, 1995 -- prescription drugs and pharmaceuticals

Payments for prescription drugs and professional pharmaceutical services shall continue to be limited to 110% of the average wholesale price on and after January 1, 1995.

§ 127.162. Medical fee updates on and after January 1, 1995 -- new allowances adopted by Commissioner

On and after January 1, 1995, if the Commissioner adopts new allowances for services provided under the act, those new allowances will be frozen immediately, and thereafter updated annually by the percentage change in the Statewide average weekly wage.

BILLING TRANSACTIONS

§ 127.201. Medical bills -- standard forms

(a) Requests for payment of medical bills shall be made either on the HCFA Form 1500 or the UB92 Form (HCFA Form 1450), or any successor forms, required by HCFA for submission of Medicare claims. If HCFA accepts a form for submission of Medicare claims by a certain provider, that form shall be acceptable for billing under the act.

(b) Cost-based providers shall submit a detailed bill including the service codes consistent with the service codes submitted to the Bureau on the detailed charge master in accordance with § 127.155(b) (relating to medical fee updates on and after January 1, 1995 -- outpatient acute care providers, specialty hospitals and other cost-reimbursed providers), or consistent with new service codes added under § 127.155(d) and (e).

§ 127.202. Medical bills -- use of alternative forms

(a) Until a provider submits bills on one of the forms specified in § 127.201 (relating to medical bills -- standard forms) insurers are not required to pay for the treatment billed.

(b) Insurers may not require providers to use any form of medical bill other than the forms required by § 127.201.

RULES AND REGULATIONS

§ 127.203. Medical bills -- submission of medical reports

(a) Providers who treat injured employees are required to submit periodic medical reports to the employer, commencing 10 days after treatment begins and at least once a month thereafter as long as treatment continues. If the employer is covered by an insurer, the provider shall submit the report to the insurer.

(b) Medical reports are not required to be submitted in months during which treatment has not been rendered.

(c) The medical reports required by subsection (a) shall be submitted on a form prescribed by the Bureau for that purpose. The form shall require the provider to supply, when pertinent, information on the claimant's history, the diagnosis, a description of the treatment and services rendered, the physical findings and the prognosis, including whether or not there has been recovery enabling the claimant to return to pre-injury work without limitations. Providers shall supply only the information applicable to the treatment or services rendered.

(d) If a provider does not submit the required medical reports on the prescribed form, the insurer is not obligated to pay for the treatment covered by the report until the required report is received by the insurer.

§ 127.204. Fragmenting or unbundling of charges by providers

A provider may not fragment or unbundle charges except as consistent with Medicare.

§ 127.205. Calculation of amount of payment due to providers

Bills submitted by providers for payment shall state the provider's actual charges for the treatment rendered. A provider's statement of actual charges will not be construed to be an unlawful request or requirement for payment in excess of the medical fee caps. The insurer to whom the bill is submitted shall calculate the proper amount of payment for the treatment rendered.

§ 127.206. Payment of medical bills -- request for additional documentation

Insurers may request additional documentation to support medical bills submitted for payment by providers, as long as the additional documentation is relevant to the treatment for which payment is sought.

§ 127.207. Downcoding by insurers

(a) Changes to a provider's codes by an insurer may be made if the following conditions are met:

- (1) The provider has been notified in writing of the proposed changes and the reasons in support of the changes.
- (2) The provider has been given an opportunity to discuss the proposed changes and support the original coding decisions.
- (3) The insurer has sufficient information to make the changes.
- (4) The changes are consistent with Medicare guidelines, the act and this subchapter.

(b) For purposes of subsection (a)(1), the provider shall be given 10 days to respond to the notice of the proposed changes, and the insurer must have written evidence of the date notice was sent to the provider.

(c) Whenever changes to a provider's billing codes are made, the insurer shall state the reasons why the provider's original codes were changed in the explanation of benefits required by § 127.209 (relating to explanation of benefits paid).

RULES AND REGULATIONS

(d) If an insurer changes a provider's codes without strict compliance with subsections (a) -- (c), the Bureau will resolve an application for fee review filed under § 127.252 (relating to application for fee review -- filing and service) in favor of the provider under § 127.254 (relating to downcoding disputes).

§ 127.208. Time for payment of medical bills

(a) Payments for treatment rendered under the act shall be made within 30 days of receipt of the bill and report submitted by the provider.

(b) For purposes of computing the timeliness of payments, the insurer shall be deemed to have received a bill and report 3 days after mailing by the provider. Payments shall be deemed timely made if mailed on or before the 30th day following receipt of the bill and report.

(c) If an insurer requests additional information or records from a provider, the request may not lengthen the 30-day period in which payment shall be made to the provider.

(d) If an insurer proposes to change a provider's codes, the time required to give the provider the opportunity to discuss the proposed changes may not lengthen the 30-day period in which payment shall be made to the provider.

(e) The 30-day period in which payment shall be made to the provider may be tolled only if review of the reasonableness or necessity of the treatment is requested during the 30-day period under the UR provisions of Subchapter C (relating to medical treatment review). The insurer's right to suspend payment shall continue throughout the UR process. The insurer's right to suspend payment shall further continue beyond the UR process to a proceeding before a workers' compensation judge, unless there is a UR determination made that the treatment is reasonable and necessary.

(f) The nonpayment to providers within 30 days shall only apply to that particular treatment or portion thereof in dispute. If a portion of the treatment is not in dispute, payment shall be made within 30 days.

(g) If a URO determines that medical treatment is reasonable or necessary, the insurer shall pay for the treatment. Filing a petition for review before a workers' compensation judge, does not further suspend the obligation to pay for the treatment once there has been a determination that the treatment is reasonable or necessary. If it is finally determined that the treatment was not reasonable or necessary, and the insurer paid for the treatment in accordance with this chapter, the insurer may seek reimbursement from the Supersedeas Fund under section 443(a) of the act (77 P. S. § 999(a)).

§ 127.209. Explanation of benefits paid

(a) Insurers shall supply a written explanation of benefits (EOB) to the provider, describing the calculation of payment of medical bills submitted by the provider. If payment is based on changes to a provider's codes, the EOB shall state the reasons for changing the original codes. If payment of a bill is denied entirely, insurers shall provide a written explanation for the denial.

(b) All EOBs shall contain the following notice: "Health care providers are prohibited from billing for, or otherwise attempting to recover from the employe, the difference between the provider's charge and the amount paid on this bill."

§ 127.210. Interest on untimely payments

(a) If an insurer fails to pay the entire bill within 30 days of receipt of the required bills and medical reports, interest shall accrue on the due and unpaid balance at 10% per annum under section 406.1(a) of the act (77 P. S. § 717.1).

RULES AND REGULATIONS

(b) If an insurer fails to pay any portion of a bill, interest shall accrue at 10% per annum on the unpaid balance.

(c) Interest shall accrue on unpaid medical bills even if an insurer initially denies liability for the bills if liability is later admitted or determined.

(d) Interest shall accrue on unpaid medical bills even if an insurer has filed a request for UR under Subchapter C (relating to medical treatment review) if a later determination is made that the insurer was liable for paying the bills.

§ 127.211. Balance billing prohibited

(a) A provider may not hold an employe liable for costs related to care or services rendered in connection with a compensable injury under the act. A provider may not bill for, or otherwise attempt to recover from the employe, the difference between the provider's charge and the amount paid by an insurer.

(b) A provider may not bill for, or otherwise attempt to recover from the employe, charges for treatment or services determined to be unreasonable or unnecessary in accordance with the act or Subchapter C (relating to medical treatment review).

REVIEW OF MEDICAL FEE DISPUTES

§ 127.251. Medical fee disputes -- review by the Bureau

A provider who has submitted the required bills and reports to an insurer and who disputes the amount or timeliness of the payment made by an insurer, shall have standing to seek review of the fee dispute by the Bureau.

§ 127.252. Application for fee review -- filing and service

(a) Providers seeking review of fee disputes shall file the original and one copy of a form prescribed by the Bureau as an application for fee review. The application shall be filed no more than 30 days following notification of a disputed treatment or 90 days following the original billing date of the treatment which is the subject of the fee dispute, whichever is later. The form shall be accompanied by documentation required by § 127.253 (relating to application for fee review -- documents required generally).

(b) Providers shall serve a copy for the application for fee review, and the attached documents, upon the insurer. Proof of service shall accompany the application for fee review and shall indicate the person served, the date of service and the form of service.

(c) Providers shall send the application for fee review and all related attachments to the address for the Bureau listed on the application form.

(d) The time for filing an application for fee review will be tolled if the insurer has the right to suspend payment to the provider due to a dispute regarding the reasonableness and necessity of the treatment under Subchapter C (relating to medical treatment review).

§ 127.253. Application for fee review -- documents required generally

(a) Providers reimbursed under the Medicare Part B Program shall submit the following documents with their application for fee review:

- (1) The applicable Medicare billing form.

RULES AND REGULATIONS

(2) The required medical report form, together with office notes and documentation supporting the procedures performed or services rendered.

(3) The explanation of benefits, if available.

(b) Providers reimbursed under the Medicare Part A Program and providers reimbursed by Medicare based on HCFA Forms 2552, 2540, 2088 or 1728, or successor forms, shall submit the following documents with the application for fee review:

(1) The applicable Medicare billing form.

(2) The most recent Medicare interim rate notification.

(3) The most recent Notice of Program Reimbursement.

(4) The most recently audited Medicare cost report.

(5) The required medical report form, together with documentation supporting the procedures performed or services rendered.

(6) The explanation of benefits, if available.

(c) For treatment rendered on and after January 1, 1995, the items specified in subsections (b)(2) -- (4) shall be submitted if the requirements of § 127.155 (relating to medical fee updates on and after January 1, 1995 -- outpatient acute care providers, specialty hospitals and other cost-reimbursed providers) have been met.

§ 127.254. Downcoding disputes

(a) When changes in procedure codes are the basis for a fee dispute, the Bureau will give the provider and the insurer the opportunity to produce copies of written communications concerning the changes in procedure codes.

(b) If an insurer has not complied with § 127.207 (relating to downcoding by insurers) the Bureau will resolve downcoding disputes in favor of the provider.

§ 127.255. Premature applications for fee review

The Bureau will return applications for fee review prematurely filed by providers when one of the following exists:

(1) The insurer denies liability for the alleged work injury.

(2) The insurer has filed a request for utilization review of the treatment under Subchapter C (relating to medical treatment review).

(3) The 30-day period allowed for payment has not yet elapsed, as computed under § 127.208 (relating to time for payment of medical bills).

§ 127.256. Administrative decision on an application for fee review

When a provider has filed all the documentation required and is entitled to a decision on the merits of the application for fee review, the Bureau will render an administrative decision within 30 days of receipt of all required documentation from the provider. The Bureau will, prior to rendering the administrative decision, investigate the matter and contact the insurer to obtain its response to the application for fee review.

RULES AND REGULATIONS

§ 127.257. Contesting an administrative decision on a fee review

- (a) A provider or insurer shall have the right to contest an adverse administrative decision on an application for fee review.
- (b) The party contesting the administrative decision shall file an original and seven copies of a written request for a hearing with the Bureau within 30 days of the date of the administrative decision on the fee review. The hearing request shall be mailed to the Bureau at the address listed on the administrative decision.
- (c) A copy of the request for a hearing shall be served upon the prevailing party in the fee dispute. A proof of service, indicating the person served, the date of service and the form of service, shall be provided to the Bureau at the time the request for hearing is filed.
- (d) An untimely request for a hearing may be dismissed without further action by the Bureau.
- (e) Filing of a request for a hearing shall act as a supersedeas of the administrative decision on the fee review.

§ 127.258. Bureau as intervenor

The Bureau may, as an intervenor in the fee review matter, defend the Bureau's initial administrative decision on the fee review.

§ 127.259. Fee review hearing

- (a) The Bureau will assign the request for a hearing to a hearing officer who will schedule a de novo proceeding. All parties will receive reasonable notice of the hearing date, time and place.
- (b) The hearing will be conducted in a manner to provide all parties the opportunity to be heard. The hearing officer will not be bound by strict rules of evidence. All relevant evidence of reasonably probative value may be received into evidence. Reasonable examination and cross-examination of witnesses will be permitted.
- (c) The parties may be represented by legal counsel, but legal representation at the hearing is not required.
- (d) Testimony will be recorded and a full record kept of the proceeding.
- (e) All parties will be provided the opportunity to submit briefs addressing issues raised.
- (f) The insurer shall have the burden of proving by a preponderance of the evidence that it properly reimbursed the provider.

§ 127.260. Fee review adjudications

- (a) The hearing officer will issue a written decision and order within 90 days following the close of the record. The decision will include all relevant findings and conclusions, and state the rationale for the fee review adjudication.
- (b) The fee review adjudication will include a notification to all parties of appeal rights to Commonwealth Court.
- (c) The fee review adjudication will be served upon all parties, intervenors and counsel of record.

RULES AND REGULATIONS

§ 127.261. Further appeal rights

Any party aggrieved by a fee review adjudication rendered pursuant to § 127.260 (relating to fee review adjudications) may file an appeal to Commonwealth Court within 30 days from mailing of the decision.

SELF-REFERRALS

§ 127.301. Referral standards

(a) Under section 306(f.1)(3)(iii) of the act (77 P. S. § 531(3)(iii)), a provider may not refer a person for certain treatment and services if the provider has a financial interest with the person or in the entity that receives the referral. A provider may not enter into an arrangement or scheme, such as a cross-referral arrangement, which the provider knows, or should know, has a principal purpose of assuring referrals by the provider to a particular entity which, if the provider directly made referrals to the entity, would be in violation of the act.

(b) No claim for payment may be presented by a person, provider or entity for a service furnished under a referral prohibited under subsection (a).

(c) Referrals permitted under all present and future Safe Harbor regulations promulgated under the Medicare and Medicaid Patient and Program Protection Act at 42 U.S.C.A. § 1320a-7b(1) and (2), published at 42 CFR 1001.952 (relating to exceptions), and all present and future exceptions to the Stark amendments to the Medicare Act at 42 U.S.C.A. § 1395nn, and all present and future regulations promulgated thereunder are not prohibited referrals involving financial interest. An insurer may not deny payment to a health care provider involved in such transaction or referral.

(d) For purposes of section 306(f.1)(3)(iii) of the act, a CCO will be considered a single health care provider.

§ 127.302. Resolution of self-referral disputes by Bureau

(a) If an insurer determines that a bill has been submitted for treatment rendered in violation of the referral standards, the insurer is not liable to pay the bill. Within 30 days of receipt of the provider's bill and medical report, the insurer shall supply a written explanation of benefits, under § 127.209 (relating to explanation of benefits paid), stating the basis for believing that the self-referral provision has been violated.

(b) A provider who has been denied payment of a bill under subsection (a) may file an application for fee review with the Bureau under § 127.251 (relating to medical fee disputes -- review by the Bureau) An application for fee review filed under this subsection will be assigned to a hearing officer for a hearing and adjudication in accordance with the procedures set forth in §§ 127.259 and 127.260 (relating to fee review hearing; and fee review adjudications).

(c) The insurer shall have the burden of proving by a preponderance of the evidence that a violation of the self-referral provisions has occurred.

SUBCHAPTER C. MEDICAL TREATMENT REVIEW

UR -- GENERAL REQUIREMENTS

§ 127.401. Purpose/review of medical treatment

(a) Section 306(f.1)(6) of the act (77 P. S. § 531(6)) provides a UR process, intended as an impartial review of the reasonableness or necessity of medical treatment rendered to, or proposed for, work-related injuries and illnesses.

RULES AND REGULATIONS

(b) UR of medical treatment shall be conducted only by those organizations authorized as UROs by the Secretary, under the process in §§ 127.651 -- 127.670 (relating to authorization of UROs and PROs).

(c) UR may be requested by or on behalf of the employer, insurer or employe.

(d) A party, including a health care provider, aggrieved by the UR determination, may file a petition for review of UR, to be heard and decided by a workers' compensation judge.

§ 127.402. Treatment subject to review

Treatment for work-related injuries rendered on and after August 31, 1993, may be subject to review.

§ 127.403. Assignment of cases to UROs by the Bureau

The Bureau will randomly assign requests for UR to authorized UROs. An insurer's obligation to pay medical bills within 30 days of receipt shall be tolled only when a proper request for UR has been filed with the Bureau in accordance with this subchapter.

§ 127.404. Prospective, concurrent and retrospective review

(a) UR of treatment may be prospective, concurrent or retrospective, and may be requested by any party eligible to request UR under § 127.401(c) (relating to purpose/review of medical treatment).

(b) If an insurer or employer seeks retrospective review of treatment, the request for UR shall be filed within 30 days of the receipt of the bill and medical report for the treatment at issue. Failure to comply with the 30-day time period shall result in a waiver of retrospective review. If the insurer is contesting liability for the underlying claim, the 30 days in which to request retrospective UR is tolled pending an acceptance or determination of liability.

(c) If an employe files a request for UR of treatment, the Bureau will confirm whether the insurer is liable for the underlying alleged work injury. The Bureau will process the UR request only when workers' compensation liability for the underlying injury has been accepted or determined.

(d) If an employe files a request for UR of prospective treatment which satisfies the requirements of subsection (c), the Bureau will determine whether the insurer is denying payment for the treatment.

(1) The Bureau will send a copy of the employe's request for UR to the insurer, together with a written notice asking the insurer whether it will accept payment for the treatment or is denying payment for the treatment. The insurer shall respond in writing to the Bureau's written notice within 7 days of receipt of the notice.

(2) If the insurer responds that it is willing to accept payment for the treatment, the Bureau will not process the employe's request for UR. After the treatment at issue has been provided, the insurer may not request, and the Bureau will not process, a retrospective UR on the same treatment. The insurer shall pay for the treatment as if there had been an uncontested UR determination finding the treatment to be reasonable or necessary.

(3) If the insurer is denying payment for the treatment, the insurer shall state the reasons for the denial in its written response. If no reasons are stated for the denial, or if the insurer's written response to the Bureau notice is untimely, the insurer shall pay for the cost of the UR and pay for treatment found to be reasonable or necessary by an uncontested UR determination.

(4) If the insurer responds in writing to the Bureau's notice by denying a causal relationship between the work-related injury and the treatment, the Bureau will not process the employe's UR request until the underlying liability is either accepted by the insurer or determined by a Workers' Compensation judge.

RULES AND REGULATIONS

§ 127.405. UR of medical treatment in medical only cases

(a) In medical only cases, when an insurer is paying for an injured worker's medical treatment but has not either filed documents with the Bureau admitting liability for a work-related injury nor has there been a determination to the effect, the insurer may still seek review of the reasonableness or necessity of the treatment by filing a request for UR.

(b) If the insurer files a request for UR in a medical only case, the insurer is responsible for paying for the costs of the UR.

(c) If the insurer files a request for UR in a medical only case, then the insurer shall be liable to pay for treatment found to be reasonable or necessary by an uncontested UR determination.

§ 127.406. Scope of review of UROs

(a) UROs shall decide only the reasonableness or necessity of the treatment under review.

(b) UROs may not decide any of the following issues:

- (1) The causal relationship between the treatment under review and the employe's work-related injury.
- (2) Whether the employe is still disabled.
- (3) Whether "maximum medical improvement" has been obtained.
- (4) Whether the provider performed the treatment under review as a result of an unlawful self-referral.
- (5) The reasonableness of the fees charged by the provider.
- (6) The appropriateness of the diagnostic or procedural codes used by the provider for billing purposes.
- (7) Other issues which do not directly relate to the reasonableness or necessity of the treatment under review.

§ 127.407. Extent of review of medical records

(a) In order to determine the reasonableness or necessity of the treatment under review, UROs shall obtain for review all available records of all treatment rendered by all providers to the employe for the work-related injury. However, the UR determination shall be limited to the treatment that is subject to review by the request.

(b) UROs may not obtain or review medical records of treatment which are not related to the work injury.

UR -- INITIAL REQUEST

§ 127.451. Requests for UR -- who may file

Requests for UR may be filed by an employe, employer or insurer. Health care providers may not file requests for UR.

§ 127.452. Requests for UR -- filing and service

(a) A party seeking UR of treatment rendered under the act shall file the original and 8 copies of a form prescribed by the Bureau as a request for UR. All information required by the form shall be provided. If available, the filing party shall attach authorizations to release medical records of the providers listed on the request.

RULES AND REGULATIONS

(b) The request for UR shall be served on all parties and their counsel, if known, and the proof of service on the form shall be executed. If the proof of service is not executed, the request for UR will be returned by the Bureau.

(c) Requests for UR shall be sent to the Bureau at the address listed on the form.

(d) The request for UR shall identify the provider under review. Except as specified in subsection (e), the provider under review shall be the provider who rendered the treatment or service which is the subject of the UR request.

(e) When the treatment or service requested to be reviewed is anesthesia, incident to surgical procedures, diagnostic tests, prescriptions or durable medical equipment, the request for UR shall identify the provider who made the referral, ordered or prescribed the treatment or service as the provider under review.

§ 127.453. Requests for UR -- assignment by the Bureau

(a) The Bureau will randomly assign a properly filed request for UR to an authorized URO.

(b) The Bureau will send a notice of assignment of the request for UR to the URO; the employee; the employer or insurer; the health care provider under review; and the attorneys for the parties, if known.

§ 127.454. Requests for UR – reassignment

(a) If a URO is unable, for any reason, to perform a request for UR assigned to it by the Bureau, the URO shall, within 5 days of receipt of the assignment, return the request for UR to the Bureau for reassignment.

(b) A URO may not directly reassign a request for UR to another URO.

(c) A URO shall return a request for UR assigned to it by the Bureau if the URO has a conflict of interest with the request, as set out in § 127.455 (relating to requests for UR -- conflicts of interest).

§ 127.455. Requests for UR -- conflicts of interest

(a) A URO shall be deemed to have a conflict of interest and shall return a request for UR to the Bureau for reassignment if one or more of the following exist:

(1) The URO has a previous involvement with the patient or with the provider under review, regarding the same underlying claim.

(2) The URO has performed precertification functions in the same matter.

(3) The URO has provided case management services in the same matter.

(4) The URO has provided vocational rehabilitation services in the same matter.

(5) The URO is owned by or has a contractual arrangement with any party subject to the review.

(b) A URO shall inform the reviewer assigned to perform UR of the reviewer's obligation to notify the URO of any potential or realized conflicts arising under § 127.468 (relating to duties of reviewers -- conflict of interest).

§ 127.456. Requests for UR – withdrawal

(a) A party who wishes to withdraw a request for UR shall notify the Bureau of the withdrawal in writing. The withdrawal notice may not be sent directly to the URO.

(b) The Bureau will promptly notify the URO of the withdrawal.

RULES AND REGULATIONS

(c) The insurer or employer shall pay the costs incurred by the URO prior to the withdrawal.

(d) A withdrawal of a request for UR shall be with prejudice.

§ 127.457. Time for requesting medical records

A URO shall request records from the treating providers listed on the request for UR within 5 days from receipt of the Bureau's notice of assignment.

§ 127.458. Obtaining authorization to release medical records

If a request for UR does not have the necessary authorizations to release records attached to it, the URO may contact the providers or insurer to obtain the necessary authorizations.

§ 127.459. Obtaining medical records -- provider under review

(a) A URO shall request records from the provider under review in writing. The written request for records shall be by certified mail, return receipt requested. In addition, the URO may request the records from the provider under review by telephone.

(b) The medical records of the provider under review may not be requested from, or supplied by, any source other than the provider under review.

(c) The provider under review, or his agent, shall sign a verification that, to the best of his knowledge, the medical records provided constitute the true and complete medical chart as it relates to the employee's work-injury.

§ 127.460. Obtaining medical records -- other treating providers

(a) A URO shall request records from other treating providers in writing. In addition, the URO may request records from other treating providers by telephone.

(b) A provider, or his agent, who supplies medical records to a URO pursuant to this section shall sign a verification that, to the best of his knowledge, the medical records constitute the true and complete medical chart as it relates to the employee's work injury.

(c) If a URO is not able to obtain records directly from the other treating providers, it may obtain these records from the insurer, the employer or the employee.

(d) If an insurer, employer or employee supplies medical records to a URO under subsection (c), it shall sign a verification that, to the best of its knowledge, the records supplied are the complete set of records as received from the provider that relate to the work-injury and that the records have not been altered in any manner.

§ 127.461. Obtaining medical records -- independent medical exams

UROs may not request, and the parties may not supply, reports of independent medical examinations performed at the request of an insurer, employer, employee or attorney. Only the records of actual treating health care providers shall be requested by, or supplied to, a URO.

§ 127.462. Obtaining medical records -- duration of treatment

UROs shall attempt to obtain records from all providers for the entire course of treatment rendered to the employee for the work-related injury which is the subject of the UR request, regardless of the period of treatment under review.

RULES AND REGULATIONS

§ 127.463. Obtaining medical records -- reimbursement of costs of provider

(a) The URO shall, within 30 days of receiving medical records, reimburse the provider for record copying costs at the rate specified by Medicare and for actual postage costs. The Bureau will publish the Medicare rate in the Pennsylvania Bulletin as a notice when the rate changes.

(b) Reproduction of radiologic films shall be reimbursed at the usual and customary charge. The cost of reproducing such films shall be itemized separately when the URO bills for performing the UR.

§ 127.464. Effect of failure of provider under review to supply records

(a) If the provider under review fails to mail records to the URO within 30 days of the date of request of the records, the URO shall render a determination that the treatment under review was not reasonable or necessary, if the conditions set forth in subsection (b) have been met.

(b) Before rendering the determination against the provider, a URO shall do the following:

(1) Determine whether the records were mailed in a timely manner.

(2) Indicate on the determination that the records were requested but not provided.

(3) Adequately document the attempt to obtain records from the provider under review, including a copy of the certified mail return receipt from the request for records.

(c) If the URO renders a determination against the provider under subsection (a), it may not assign the request to a reviewer.

§ 127.465. Requests for UR -- deadline for URO determination

(a) A request for UR shall be deemed complete upon receipt of the medical records or 35 days from the date of the notice of assignment, whichever is earlier.

(b) A URO shall complete its review, and render its determination, within 30 days of a completed request for UR.

§ 127.466. Assignment of UR request to reviewer by URO

Upon receipt of the medical records, the URO shall forward the records, the request for UR, the notice of assignment and a Bureau-prescribed instruction sheet to a reviewer licensed by the Commonwealth in the same profession and having the same specialty as the provider under review.

§ 127.467. Duties of reviewers – generally

Reviewers shall apply generally accepted treatment protocols as appropriate to the individual case before them.

§ 127.468. Duties of reviewers – conflict of interest

A reviewer shall return a review to the URO for assignment to another reviewer if one or more of the following exist:

(1) The reviewer has a previous involvement with the patient, or with the provider under review, regarding the same matter.

RULES AND REGULATIONS

- (2) The reviewer has performed precertification functions in the same matter.
- (3) The reviewer has provided case management services in the same matter.
- (4) The reviewer has provided vocational rehabilitation services in the same matter.
- (5) The reviewer has a contractual relationship with any party in the matter.

§ 127.469. Duties of reviewers -- consultation with provider under review

The URO shall give the provider under review written notice of the opportunity to discuss treatment decisions with the reviewer. The reviewer shall initiate discussion with the provider under review when such a discussion will assist the reviewer in reaching a determination. If the provider under review declines to discuss treatment decisions with the reviewer, a determination shall be made in the absence of such a discussion.

§ 127.470. Duties of reviewers -- issues reviewed

(a) Reviewers shall decide only the issue of whether the treatment under review is reasonable or necessary for the medical condition of the employee.

(b) Reviewers shall assume the existence of a causal relationship between the treatment under review and the employee's work-related injury. Reviewers may not consider or decide issues such as whether the employee is still disabled, whether maximum medical improvement has been obtained, quality of care or the reasonableness of fees.

§ 127.471. Duties of reviewers -- finality of decisions

(a) Reviewers shall make a definite determination as to whether the treatment under review is reasonable or necessary. Reviewers may not render advisory opinions as to whether additional tests are needed. In determining whether the treatment under review is reasonable or necessary, reviewers may consider whether other courses of treatment exist. However, reviewers may not determine that the treatment under review is unreasonable or unnecessary solely on the basis that other courses of treatment exist.

(b) If the reviewer is unable to determine whether the treatment under review is reasonable or necessary, the reviewer shall resolve the issue in favor of the provider under review.

§ 127.472. Duties of reviewers -- content of reports

The written reports of reviewers shall contain, at a minimum, the following elements: a listing of the records reviewed; documentation of any actual or attempted contacts with the provider under review; findings and conclusions; and a detailed explanation of the reasons for the conclusions reached by the reviewer, citing generally accepted treatment protocols and medical literature as appropriate.

§ 127.473. Duties of reviewers -- signature and verification

(a) Reviewers shall sign their reports. Signature stamps may not be used.

(b) Reviewers shall sign a verification pursuant to 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) that the reviewer personally reviewed the records and that the report reflects the medical opinions of the reviewer.

§ 127.474. Duties of reviewers -- forwarding report and records to URO

Reviewers shall forward their reports and all records reviewed to the URO upon completion of the report.

RULES AND REGULATIONS

§ 127.475. Duties of UROs -- review of report

- (a) UROs shall check the reviewer's report to ensure that the reviewer has complied with formal requirements (such as signature and verification).
- (b) UROs shall ensure that all records have been returned by the reviewer.
- (c) A URO may not contact a reviewer and attempt to persuade the reviewer to change the medical opinions expressed in a report.

§ 127.476. Duties of UROs -- form and service of determinations

- (a) Each determination rendered by a URO on the merits shall include a form prescribed by the Bureau as a medical treatment review determination face sheet and the reviewer's report. The face sheet shall be signed by an authorized representative of the URO.
- (b) When a determination is rendered against the provider under review on the basis that no records were supplied by the provider, the determination shall consist only of the face sheet. However, in these cases, the face sheet shall clearly indicate that the basis for the decision is the failure of the provider under review to supply records to the URO.
- (c) The URO's determination, consisting of both the face sheet and the reviewer's report, shall be served on the employe, the insurer or employer, the provider under review, the attorneys for the parties, if known, and the Bureau.
- (d) The URO shall also serve a copy of a petition for review of a UR determination on all parties and their attorneys, if known.
- (e) Service shall be made by certified mail, return receipt requested and shall be made on the same date as is entered on the appropriate line of the face sheet.

§ 127.477. Payment for request for UR

The insurer or the employer shall pay the reasonable and customary charge of the URO for the UR determination, regardless of who the requesting party is. Payment shall be made within 30 days of the date the UR determination was received. The URO shall send its itemized bill to the insurer responsible for payment and a copy of the itemized bill to the Bureau.

§ 127.478. Record retention requirements for UROs

- (a) UROs shall retain records relating to URs for 1 year from the date that a determination was rendered. These records shall include, but are not limited to, the notice of assignment, all correspondence, all certified mail return receipts and documents, all medical records reviewed, the face sheet and the reviewer's report.
- (b) The URO's files will be subject to inspection and audit by the Bureau without notice.

§ 127.479. Determination against insurer -- payment of medical bills

If the UR determination finds that the treatment reviewed was reasonable or necessary, the insurer shall pay the bills submitted for the treatment in accordance with § 127.208 (relating to time for payment of medical bills).

§§ 127.501. – 127.515. [Reserved]

RULES AND REGULATIONS

UR -- PETITION FOR REVIEW

§ 127.551. Petition for review by Bureau of UR determination

If the provider under review, the employe, the employer or the insurer disagrees with the determination rendered by the URO, a request for review by the Bureau may be filed on a form prescribed by the Bureau as a petition for review of a UR determination.

§ 127.552. Petition for review by Bureau -- time for filing

The original and eight copies of the petition for review shall be filed with the Bureau within 30 days of receipt of the URO's determination.

§ 127.553. Petition for review by Bureau -- notice of assignment and service by Bureau

(a) The Bureau will assign the petition for review to a workers' compensation judge. The Bureau will serve the notice of assignment and the petition for review upon the URO, the employe, the employer or insurer, the health care provider under review, and the attorneys for the parties, if known.

(b) When a petition for review is filed in a case already in litigation before a workers' compensation judge, the Bureau will assign the petition for review to the workers' compensation judge who is hearing the case-in-chief.

(c) Before assigning a petition for review, the Bureau will review the petition to ensure that a UR has been filed and a determination has been rendered.

§ 127.554. Petition for Review by Bureau -- no answer allowed

No answer to the petition for review may be filed.

§ 127.555. Petition for review by Bureau -- transmission of URO records to workers' compensation judge

(a) Upon the workers' compensation judge's own motion, or motion of any party to the proceeding, the workers' compensation judge may order the URO to forward all medical records obtained for its review to the workers' compensation judge. The URO shall forward all records within 10 days of the date of the workers' compensation judge's order.

(b) When a petition for review has been filed, the Bureau will forward the URO report to the workers' compensation judge assigned to the case.

(c) An authorized agent of the URO shall sign a verification stating that, to the best of his knowledge, the complete set of unaltered records obtained by the URO is being transmitted to the workers' compensation judge.

(d) When records are provided under subsection (a), the URO shall transmit its itemized bill for record copying costs to the manager of the Medical Treatment Review Section, together with a copy of the workers' compensation judge's order directing the URO to provide the records. The URO shall be reimbursed by the Bureau for its record copying costs at the rate specified by Medicare, and for actual postage costs. Reproduction of radiologic films shall be reimbursed at a reasonable cost.

§ 127.556. Petition for Review by Bureau -- de novo hearing

The hearing before the workers' compensation judge shall be a de novo proceeding. The URO report shall be part of the record before the workers' compensation judge and the workers' compensation judge shall consider the report as evidence. The workers' compensation judge will not be bound by the URO report.

RULES AND REGULATIONS

PEER REVIEW

§ 127.601. Peer review – availability

(a) A Workers' Compensation judge may obtain an opinion from an authorized PRO concerning the necessity or frequency of treatment rendered under the act when one of the following exist:

(1) A petition for review of a UR determination has been filed.

(2) It is necessary or appropriate in other litigation proceedings before the Worker's Compensation judge. Peer review shall be deemed not to be necessary or appropriate if there is a pending UR of the same treatment.

(b) Nothing in subsection (a) requires a Workers' Compensation judge to grant a party's motion for peer review.

§ 127.602. Peer review -- procedure upon motion of party

(a) A party may not make a motion for peer review if the same course of treatment has been submitted for UR.

(b) After making a motion for peer review, neither party may file a request for UR while the motion is pending. If the motion is not specifically ruled on within 10 days, then it shall be deemed denied.

(c) If the Workers' Compensation judge has not ruled on the motion within 10 days, or if the motion is denied, the parties shall be free to file requests for UR.

(d) If the motion is granted, the Workers' Compensation judge will proceed in accordance with § 127.604 (relating to peer review -- forwarding a request to the Bureau).

§ 127.603. Peer review -- interlocutory ruling

The ruling on a motion for peer review shall be deemed interlocutory.

§ 127.604. Peer review -- forwarding of request to Bureau

(a) If the Workers' Compensation judge decides that peer review is necessary or appropriate, the Judge will forward a request for peer review to the Bureau on a form prescribed by the Bureau. The Workers' Compensation judge will notify counsel, or the parties, if unrepresented, by serving a copy of the request for peer review upon them.

(b) In cases other than petitions for review of a UR determination, the Worker's Compensation judge will attach subpoenas to the request for peer review which the assigned PRO shall use to obtain medical records.

§ 127.605. Peer review -- assignment by the Bureau

(a) The Bureau will randomly assign a properly filed request for peer review to an authorized PRO.

(b) The Bureau will send a notice of assignment of the request for peer review to the PRO, the Workers' Compensation judge, counsel for the parties, or the parties, if unrepresented, and the health care provider under review.

RULES AND REGULATIONS

§ 127.606. Peer review – reassignment

- (a) If a PRO is unable, for any reason, to perform a peer review assigned to it by the Bureau, the PRO shall, within 5 days of receipt of the assignment, return the request for peer review to the Bureau for reassignment.
- (b) A PRO may not, under any circumstances, reassign a request for peer review to another PRO.
- (c) A PRO shall return requests for peer review assigned to it by the Bureau if the PRO has a conflict of interest in the request assigned to it.

§ 127.607. Peer review -- conflicts of interest

- (a) A PRO shall return a request for peer review to the Bureau for reassignment if the following apply:
 - (1) The PRO has a previous involvement with the patient or provider under review in the same matter.
 - (2) The PRO has performed precertification functions in the same matter.
 - (3) The PRO has provided case management services in the same matter.
 - (4) The PRO has provided vocational rehabilitation services in the same matter.
 - (5) The PRO is owned by or has a contractual relationship with any party subject to the review.
- (b) A PRO shall inform the reviewer assigned to perform peer review of the reviewer's obligation to notify the PRO of any potential or realized conflicts arising under § 127.615 (relating to duties of reviewers -- conflict of interest).

§ 127.608. Peer review – withdrawal

- (a) A request for peer review shall be withdrawn only at the direction of the Workers' Compensation judge. The Workers' Compensation judge will notify the Bureau of the withdrawal in writing.
- (b) The Bureau will promptly notify the PRO of the withdrawal. The Bureau will pay the costs incurred by the PRO prior to the withdrawal out of the Workmen's Compensation Administration Fund.
- (c) If a previously withdrawn peer review request is resubmitted to the Bureau, the Bureau will assign the matter to the PRO which handled it prior to the withdrawal.

§ 127.609. Obtaining medical records

- (a) In cases where peer review has been requested on a petition for review of a UR determination, the Workers' Compensation judge may order the URO to forward all the records received and reviewed for the purposes of the UR to the PRO assigned to perform the peer review by the Bureau.
- (b) In other cases, the PRO shall have 10 days from the date of the notice of assignment to subpoena records from treating providers.

§ 127.610. Obtaining medical records -- independent medical exams

PROs may not subpoena, request or be supplied with records of independent medical examinations performed at the request of an insurer, employer, employe or attorney. Only the records of actual treating health care providers may be subpoenaed by or supplied to a PRO.

RULES AND REGULATIONS

§ 127.611. Obtaining medical records -- duration of treatment

PROs shall attempt to obtain records from all providers for the entire course of treatment rendered to the employee for the work-related injury which is the subject of the peer review request, regardless of the period of treatment under review.

§ 127.612. Effect of failure of provider under review to supply records

(a) If the provider under review fails to mail records to the PRO within 30 days of the date of service of the subpoena for the records, the PRO shall report the provider's noncompliance with the subpoena to the Workers' Compensation judge.

(b) If the provider fails to supply records, the PRO may not assign the matter to a reviewer, and may not make a determination concerning the necessity or frequency of treatment.

§ 127.613. Assignment of peer review request to reviewer by PRO

Upon receipt of the medical records, the PRO shall forward the records, the request for peer review and the notice of assignment to a reviewer licensed by the Commonwealth in the same profession and Board-certified in the speciality or sub-specialty as the provider under review. Board-certification shall be by an accredited specialty board.

§ 127.614. Duties of reviewers – generally

Reviewers shall apply generally accepted treatment protocols, as appropriate, to the individual case before them.

§ 127.615. Duties of reviewers -- conflict of interest

A reviewer shall return a review to the PRO for assignment to another reviewer if one or more of the following exist:

- (1) The reviewer has a previous involvement with the patient or provider under review regarding the same matter.
- (2) The reviewer has performed precertification functions in the same matter.
- (3) The reviewer has provided case management services in the same matter.
- (4) The reviewer has provided vocational rehabilitation services in the same matter.
- (5) The reviewer has a contractual relationship with any party in the matter.

§ 127.616. Duties of reviewers -- consultation with provider under review

The PRO shall give the provider under review written notice of the opportunity to discuss treatment decisions with the reviewer. The reviewer shall initiate discussions with the provider under review when such a discussion will assist the reviewer in reaching a determination. If the provider under review declines to discuss treatment decisions with the reviewer, a determination shall be made in the absence of such a discussion.

§ 127.617. Duties of reviewers -- issues reviewed

(a) Reviewers shall decide only issues concerning the necessity and frequency of the treatment under review.

RULES AND REGULATIONS

(b) Reviewers shall assume the existence of a causal relationship between the treatment under review and the employee's work-related injury. The reviewer may not consider or decide issues such as whether the employee is still disabled, whether maximum medical improvement has been obtained, quality of care or the reasonableness of fees.

§ 127.618. Duties of reviewers -- finality of decisions

(a) Reviewers shall make a definite determination as to the necessity and frequency of the treatment under review. Reviewers may not render advisory opinions as to whether additional tests are needed. In determining whether the treatment under review is necessary, reviewers may consider whether other courses of treatment exist. However, reviewers may not render advisory opinions as to whether other courses of treatment are preferable.

(b) If the reviewer is unable to determine whether the treatment under review is necessary or of appropriate frequency, then the reviewer shall resolve the issue in favor of the provider under review.

§ 127.619. Duties of reviewers -- content of reports

The written reports of reviewers shall contain, at a minimum, the following elements: a listing of the records reviewed; documentation of any actual or attempted contacts with the provider under review; findings and conclusions; and a detailed explanation of the reasons for the conclusions reached by the reviewer, citing generally accepted treatment protocols and medical literature as appropriate.

§ 127.620. Duties of reviewers -- signature and verification

(a) Reviewers shall sign their reports. Signature stamps may not be used.

(b) Reviewers shall sign a verification under 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) that the reviewer personally reviewed the records and that the report reflects the medical opinions of the reviewer.

§ 127.621. Duties of reviewers -- forwarding report and records to PRO

Reviewers shall forward their reports and all records reviewed to the PRO upon completion of the report.

§ 127.622. Duties of PRO -- review of report

(a) PROs shall check the reviewer's report to ensure that formal requirements, such as signature and verification, have been complied with by the reviewer.

(b) PROs shall ensure that all records have been returned by the reviewer.

(c) A PRO may not contact a reviewer and attempt to persuade the reviewer to change the medical opinions expressed in a report.

§ 127.623. Peer review -- deadline for PRO determination

A PRO shall complete its review and render its determination within 30 days of receipt of the medical records.

§ 127.624. PRO reports -- filing with judge and service

The PRO shall file its report directly with the Workers' Compensation judge and mail copies to all the parties listed on the notice of assignment by certified mail, return receipt requested.

RULES AND REGULATIONS

§ 127.625. Record retention requirements for PROs

PROs shall comply with all the record retention requirements specified in § 127.478 (relating to record retention requirements). Their files shall be subject to inspection and audit by the Bureau without notice.

§ 127.626. PRO reports – evidence

The PRO report shall be a part of the record of the pending case. The Workers' Compensation judge will consider it as evidence but will not be bound by it.

§ 127.627. PRO reports – payment

The PRO shall submit its itemized bill to the Workers' Compensation judge for approval. The judge will forward the bill to the Bureau with an order for payment. Payment will be made from the Workmen's Compensation Administration Fund.

AUTHORIZATION OF UROs AND PROs

§ 127.651. Application

(a) Any organization seeking to be authorized as a URO or a PRO shall file an application on a form prescribed by the Bureau.

(b) Questions on the application shall be answered thoroughly and completely with the most recent information available. A rider may be attached if more space is necessary.

(c) The application shall be signed by a representative of the applicant and attested to as set forth on the application.

§ 127.652. Contents of an application to be authorized as a URO or PRO

(a) An application to be authorized as a URO or PRO shall include the following:

(1) Ownership information, including the following:

(i) A disclosure of whether the applicant is owned or controlled, directly or indirectly, by a self-insured employer, a third-party administrator, a workers' compensation insurer or a provider.

(ii) A list of the owners of the proposed URO or PRO with a 5% or greater ownership interest; and a disclosure of whether any such owner is a director or officer of a self-insured employer, a third-party administrator, a workers' compensation carrier or is a provider.

(iii) A chart of the relationship between the proposed URO or PRO, its parent and other subsidiaries of the parent corporation, if the proposed URO or PRO is a subsidiary or affiliate of another corporation.

(iv) A list of directors and officers of the proposed URO or PRO; and a disclosure of whether any such director or officer is a director or officer of a self-insured employer, a third-party administrator, a workers' compensation carrier or is a provider.

(2) An organization chart listing reporting relationships and the positions supporting the operations of the URO or PRO, particularly in the areas of UR, quality assurance and case communication

RULES AND REGULATIONS

systems. An addendum to the chart shall describe how increased utilization of the URO or PRO services will affect staffing.

- (3) A complete list of participating providers performing reviews for the URO or PRO:
 - (i) Identifying whether the provider is an employe or affiliate of or has entered into a contract or agreement with the URO or PRO.
 - (ii) Identifying the geographic area where the provider practices the provider's speciality.
 - (iii) Explaining how the contractual arrangements with providers ensure that the URO or PRO will be able to meet the requirements of the act and of this subchapter for UROs and PROs.
 - (iv) Establishing that it employs, is affiliated with, or has contracts with a sufficient number and specialty distribution of providers to perform reviews as required by the act and this subchapter.
 - (v) Including curriculum vitae of each reviewer.
- (4) A copy of generic form contracts or letters of agreement used by the applicant to contract with participating providers.
- (5) A description of the applicant's case communication system.
- (6) A description of the applicant's utilization or peer review system which demonstrates how the applicant meets the standards of this subchapter.
- (7) A description of the applicant's quality assurance system.
- (8) A description of the applicant's fee structure.

(b) Subsequent to filing its application, the URO or PRO shall advise the Bureau of any changes to the information provided under subsection (a).

(c) The obligation of a URO or PRO to advise the Bureau of any changes to the criteria in subsection (a) shall continue subsequent to approval of its application for authorization by the Bureau.

§ 127.653. Decision on application

- (a) Approval of an applicant URO or PRO will be at the discretion of the Bureau.
- (b) The Bureau, in rendering a decision on an application, will consider whether the applicant is capable of rendering impartial reviews and is capable of performing the responsibilities set forth in the act and this subchapter.
- (c) The Bureau, in rendering a decision on an application, will consider whether an applicant is owned or controlled by another applicant, or whether more than one applicant is owned or controlled by the same person or entity. The Bureau will not approve more than one application for authorization as a URO or PRO in cases of common ownership or control.
- (d) An applicant shall have the right to appeal a decision denying authorization as a URO or PRO within 30 days of the receipt of the decision. Untimely appeals will be dismissed without further action by the Bureau. A hearing will be conducted on the appeal as specified in § 127.670 (relating to hearings).

RULES AND REGULATIONS

§ 127.654. Authorization periods

The Bureau will issue authorization notices to approved UROs and PROs valid for 2 years from the date of issue, unless otherwise suspended or revoked for failure of the URO or PRO to comply with the act and this subchapter.

§ 127.655. Reauthorization

(a) A URO or PRO shall apply for reauthorization no later than 120 days prior to the expiration date of its authorization.

(b) An application for reauthorization shall include information the Bureau may require to demonstrate that the URO or PRO has been operating in accordance with the act and this subchapter, and is able to continue to operate in accordance with the act and this subchapter.

§ 127.656. General qualifications

A URO or PRO shall be capable of performing the responsibilities set forth in the act and this subchapter.

§ 127.657. Local business office

A URO or PRO shall have a business office located within this Commonwealth which is staffed and open at a minimum from 9 a.m. -- 5 p.m. Monday through Friday, except for legal holidays.

§ 127.658. Accessibility

A URO or PRO shall provide a toll-free telephone number and have adequate staff and telephone lines to handle inquiries from 9 a.m. -- 5 p.m. Monday through Friday, except for legal holidays. A URO or PRO shall also establish a mechanism to receive and record telephone calls during nonbusiness hours.

§ 127.659. Confidentiality

(a) A URO or PRO shall have in effect policies and procedures to ensure, both that all applicable State and Federal laws to protect the confidentiality of individual medical records are followed, and that the organization does not improperly disclose or release confidential medical information.

(b) A URO or PRO shall have mechanisms in place that allow a provider to verify that an individual requesting information on behalf of the review organization is a legitimate representative of the organization.

§ 127.660. Availability of reviewers

(a) A URO or PRO shall have available to it, by contractual arrangement or otherwise, the services of a sufficient number and specialty distribution of qualified physicians and other practitioner reviewers to ensure the organization can perform reviews as required by the act and this subchapter.

(b) A URO or PRO shall report changes in its list of reviewers to the Bureau within 30 days of the change.

§ 127.661. Qualifications of reviewers

(a) Each reviewer utilized by a URO or PRO shall have an active practice.

(b) To qualify as an active practice the reviewer shall spend at least 20 hours a week treating patients in a clinical practice.

RULES AND REGULATIONS

§ 127.662. Contracts with reviewers

Contracts between a URO or PRO and reviewers shall contain, at a minimum, the following:

- (1) A provision requiring the reviewer to cooperate with the UR, quality assurance and case communication systems established by the URO and PRO.
- (2) A provision requiring the reviewer to abide by the confidentiality requirements of the URO or PRO.
- (3) A provision specifying the contract termination rights and termination notice requirements for both the URO or PRO and the reviewer.

§ 127.663. UR system

- (a) UROs or PROs shall have a UR system which shall consist of documented criteria, standards and guidelines for the conduct of reviews undertaken under the act and this subchapter.
- (b) The UR system shall ensure that the reviews undertaken under the act and this subchapter are impartial reviews.

§ 127.664. Quality assurance system

A URO or PRO shall have a quality assurance system which shall consist of documented procedures to ensure that the URO/PRO and its reviewers comply with all the requirements specified in this subchapter.

§ 127.665. Case communication system

A URO or PRO shall have a case communication system which shall ensure that all communications activities required by this chapter during a UR or peer review are performed by the URO or PRO.

§ 127.666. Annual reports

A URO or PRO shall file an annual report with the Bureau on a form prescribed by the Bureau.

§ 127.667. Compensation policy

- (a) A URO or PRO shall charge a reasonable fee for its services on a flat fee or hourly basis. A URO or PRO may not charge for its services on a percentage or contingent fee basis.
- (b) The Bureau will publish in the Pennsylvania Bulletin, on an annual basis, the range of fees charged by each URO and PRO for services performed under the act and this chapter during the preceding year.

§ 127.668. Suspension of assignments

If the Bureau obtains information suggesting that a URO or PRO is not acting in accordance with the requirements of the act or this chapter, the Bureau may temporarily suspend the assignment of new reviews to the URO or PRO pending the outcome of an investigation. The suspension period may not exceed 60 days. The URO or PRO shall have the right to confer with the Chief of Medical Cost Containment Division.

§ 127.669. Revocation of authorizations

- (a) Upon investigation and following a conference with the Chief of the Medical Cost Containment Division, if the Bureau determines that a URO or PRO has violated the requirements of the act or this

RULES AND REGULATIONS

chapter, it may revoke the authorization of the URO or PRO to perform review functions under the act. Revocation of a URO or PRO's authority to perform reviews will be in writing and will advise the URO or PRO of its appeal rights.

(b) A URO or PRO whose authorization to perform reviews under the act has been revoked by the Bureau shall have the right to appeal the revocation within 30 days of the receipt of the Bureau's initial determination in accordance with the hearing process set forth in § 127.670 (relating to hearings).

§ 127.670. Hearings

(a) The Director of the Bureau will assign appeals to decisions regarding a URO and PRO's authority to review medical treatment to a hearing officer who will schedule a de novo hearing on the appeal from the initial decision. The URO/PRO will receive reasonable notice of the hearing date, time and place.

(b) The hearing will be conducted in a manner to provide the URO/PRO and the Bureau the opportunity to be heard. The hearing officer will not be bound by strict rules of evidence. All relevant evidence of reasonably probative value may be received into evidence. Reasonable examination and cross-examination of witnesses will be permitted.

(c) Testimony will be recorded and a full record kept of the proceeding. The Bureau and the URO/PRO will be provided the opportunity to submit briefs addressing issues raised.

(d) The hearing officer will issue a written adjudication within 90 days following the close of the record. The decision will include all relevant findings and conclusions, and state the rationale for the decision. The decision will be served upon the URO/PRO, the Bureau and counsel of record. The decision will include a notification to the URO/PRO and the Bureau of further appeal rights to the Commonwealth Court.

(e) The URO/PRO or the Bureau, aggrieved by a hearing officer's adjudication, may file a further appeal to Commonwealth Court.

SUBCHAPTER D. EMPLOYER LIST OF DESIGNATED PROVIDERS

§ 127.751. Employer's option to establish a list of designated health care providers

(a) Employers have the option to establish a list of designated health care providers under section 306(f.1)(1)(i) of the act (77 P. S. § 531(1)(i)).

(b) If an employer has established a list of providers which meets the requirements of the act and this subchapter, an employe with a work-related injury or illness shall seek treatment with one of the designated providers from the list. The employe shall continue to treat with the same provider or another designated provider for 90 days from the date of the first visit for the treatment of the work injury or illness.

(c) The employer may not require treatment with any one specific provider on the list, nor may the employer restrict the employe from switching from one designated provider to another designated provider.

(d) An employe may not be required to obtain emergency medical treatment from a listed provider. However, once emergency conditions no longer exist, the injured employe shall treat with a listed provider for the remainder of the 90-day period.

(e) If an employer's list of designated providers fails to comport with the act and this subchapter, the employe shall have the right to treat with a health care provider of the employe's choice from the time of the initial visit.

RULES AND REGULATIONS

(f) If an employer chooses not to establish a list of designated providers, the employe shall have the right to seek medical treatment from any provider from the time of the initial visit.

(g) If a designated provider prescribes invasive surgery for the employe, the employe may seek an additional opinion from any health care provider of the employe's choice. If the additional opinion differs from the opinion of the designated provider and the additional opinion provides a specific and detailed course of treatment, the employe shall determine which course of treatment to follow. If the employe opts to follow the course of treatment outlined by the additional opinion, the treatment shall be performed by one of the health care providers on the employer's designated list for 90 days from the date of the first visit to the provider of the additional opinion.

§ 127.752. Contents of list of designated health care providers

(a) If an employer establishes a list of designated health care providers, there shall be at least six providers on the list.

(1) At least three of the providers on the list shall be physicians.

(2) No more than four of the providers on the list may be CCOs.

(b) The employer shall include the names, addresses, telephone numbers and areas of medical specialties of the designated providers on the list.

(c) The employer shall include on the list only providers who are geographically accessible and whose specialties are appropriate based on the anticipated work-related medical problems of the employes.

(d) If the employer lists a CCO, as an option on the list of designated providers, the employer may not individually list any provider participating in that CCO, under circumstances when those individually listed providers are bound by the terms of the CCO for the treatment rendered to the injured workers.

(e) The employer may change the designated providers on a list. However, changes to the list may not affect the options available to an employe who has already commenced the 90-day treatment period.

§ 127.753. Disclosure requirements

(a) The employer may not include on the list of designated health care providers a physician or other health care provider who is employed, owned or controlled by the employer or the employer's insurer, unless employment, ownership or control is disclosed on the list.

(b) For purposes of this section, "employer's insurer" means the insurer who is responsible for paying workers' compensation under the terms of the act.

§ 127.754. Prominence of list of designated providers

If an employer chooses to establish a list of providers, the list shall be posted in prominent and readily accessible places at the worksite. These places include places used for treatment and first aid of injured employes and employe informational bulletin boards.

§ 127.755. Required notice of employe rights and duties

(a) If a list of designated providers is established, the employer shall provide a clearly written notice to an injured employe of the employe's rights and duties under section 306(f.1)(1)(i) of the act (77 P. S. § 531(1)(i)).

RULES AND REGULATIONS

- (b) The contents of the written notice shall, at a minimum, contain the following conditions:
- (1) The employe has the duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.
 - (2) The employe has the right to have all reasonable medical supplies and treatment related to the injury paid for by the employer as long as treatment is obtained from a designated provider during the 90-day period.
 - (3) The employe has the right, during this 90-day period, to switch from one health care provider on the list to another provider on the list, and that all the treatment shall be paid for by the employer.
 - (4) The employe has the right to seek treatment from a referral provider if the employe is referred to him by a designated provider, and the employer shall pay for the treatment rendered by the referral provider.
 - (5) The employe has the right to seek emergency medical treatment from any provider, but that subsequent nonemergency treatment shall be by a designated provider for the remainder of the 90-day period.
 - (6) The employee has the right to seek treatment or medical consultation from a nondesignated provider during the 90-day period, but that these services shall be at the employee's expense for the applicable 90 days.
 - (7) The employee has the right to seek treatment from any health care provider after the 90-day period has ended, and that treatment shall be paid for by the employer, if it is reasonable and necessary.
 - (8) The employee has the duty to notify the employer of treatment by a nondesignated provider within 5 days of the first visit to that provider. The employer may not be required to pay for treatment rendered by a nondesignated provider prior to receiving this notification. However, the employer shall pay for these services once notified, unless the treatment is found to be unreasonable by a URO, under Subchapter C (relating to medical treatment review).
 - (9) The employee has the right to seek an additional opinion from any health care provider of the employee's choice when a designated provider prescribes invasive surgery for the employee. If the additional opinion differs from the opinion of the designated provider and the additional opinion provides a specific and detailed course of treatment, the employee shall determine which course of treatment to follow. If the employee opts to follow the course of treatment outlined by the additional opinion, the treatment shall be performed by one of the health care providers on the employer's designated list for 90 days from the date of the first visit to the provider of the additional opinion.
- (c) The written notice to an employee of the employee's rights and duties under this section shall be provided at the time the employee is hired and immediately after the injury, or as soon thereafter as possible under the circumstances of the injury. If the employee's injuries are so severe that emergency care is required, notice of the employee's rights and duties shall be given as soon after the occurrence of the injury as is practicable.
- (d) The employer's duty under subsection (a) shall be evidenced by the employee's written acknowledgment of having been informed of and having understood the notice of the employee's rights and duties. Any failure of the employer to provide and evidence the notification relieves the employee from any duties specified in the notice, and the employer remains liable for all treatment rendered to the employee. However, an employee may not refuse to sign an acknowledgment to avoid duties specified in the notice.