Pennsylvania Workers' Compensation Act

Providing general information on the
Pennsylvania Workers' Compensation Act

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY

www.dli.pa.gov

Commonwealth of Pennsylvania
Tom Wolf | Governor

Department of Labor & Industry
Kathy M. Manderino | Secretary

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Contact Information & Resources

CONTACT INFORMATION & RESOURCES

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1171 S. Cameron Street, Room 103
Harrisburg, PA 17104-2501

Workers' Compensation Office of Adjudication**
1010 N. 7th Street, Room 318
Harrisburg, PA 17102-1400

Workers' Compensation Appeal Board
Capitol Associates Building, 3rd Floor South
901 N. 7th Street
Harrisburg, PA 17102-1412
717-783-7838

State Workers' Insurance Fund (SWIF)
100 Lackawanna Avenue
Scranton, PA 18503-1938
570-963-4635

Bureau of Workers' Compensation Contact Information

Claims Information Helpline
Toll free inside PA: 800-482-2383
Local calls and calls from outside PA: 717-772-4447

Employer Information Services Helpline
All calls: 717-772-3702

Only People with Hearing Loss
Toll free inside PA TTY: 800-362-4228
Local calls and calls from outside PA TTY: 717-772-4991

WCAIS Automated Customer Service (Searchable database through Workers' Compensation Automation and Integration System)
www.WCAIS.pa.gov

Compliance Division
717-787-3567

PA Training for Health and Safety (PATHS) *(for information relating to free workplace safety training)*
Join our Facebook page: https://www.Facebook.com/BWCPATHS
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Safety Committee Certification *(for information on safety committee certification/requirements/eligibility)*
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717-772-1635

WC Office of Adjudication Contact Information

Resource Center: 1-844-237-6316

CONTACT INFORMATION & RESOURCES

Websites

Visit www.dli.pa.gov and click on "Workers' Compensation" for general workers' compensation information from the PA Department of Labor & Industry, including:

- Downloadable Forms
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- Informational Pamphlets
- Mandatory Postings
- Medical Fee Schedule
- WC Act
- Workplace Safety Committees
- WC Insurance Information
- WC Judges' Procedures
- WC Judges' Rules
- WCOA Field Office Locations

Shop PA Heritage (to purchase copies of the Workers' Compensation Act)
www.shoppaheritage.com
717-787-5526

American Board of Medical Specialists (for information on board certification of physicians)
www.abms.org

American Medical Association (for general information on physicians)
www.ama-assn.org

American Osteopathic Association (for information on board certification of physicians)
www.osteopathic.org

Insurance Fraud Prevention Authority
www.helpstopfraud.org

Medicare Part B Reference Manual
www.highmarkmedicareservices.com/partb/refman/index.html

National Correct Coding Initiative
oig.hhs.gov/oei/reports/oei-03-02-00770.pdf

OSHA (to report unsafe working environments)
www.osha.gov

PA Bulletin Online
www.pabulletin.com

PA Code Online
www.pacode.com

PA Compensation Rating Bureau
www.pcrb.com

PA Department of Health (for information on the Emergency Medical Services Act)
www.health.pa.gov

PA Department of State

- To file complaints against health care providers: www.dos.pa.gov
- To obtain information on provider licensure: www.licensepa.state.pa.us

PA Insurance Department (for a list of workers' compensation insurers)
www.insurance.pa.gov

- Click on link for "Coverage"
- Click on link for "All Types of Coverage"
- Click on link for "Workers' Compensation"
- Click on link for "Current LCM List"

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Act of 1915, P.L. 736, No. 338, as amended.
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ARTICLE I
Interpretation and Definitions

Sec 101 That this act shall be called and cited as the Workers' Compensation Act, and shall apply to all injuries occurring within this Commonwealth, irrespective of the place where the contract of hiring was made, renewed, or extended, and extraterritorially as provided by section 305.2.

Sec 102 Wherever in this act the singular is used, the plural shall be included; where the masculine gender is used, the feminine and neuter shall be included.

Sec 103 The term "employer," as used in this act, is declared to be synonymous with master, and to include natural persons, partnerships, joint-stock companies, corporations for profit, corporations not for profit, municipal corporations, the Commonwealth, and all governmental agencies created by it.

Sec 104 The term "employe," as used in this act is declared to be synonymous with servant, and includes— All natural persons who perform services for another for a valuable consideration, exclusive of persons subject to coverage under the Longshore and Harbor Workers' Compensation Act (44 Stat. 1424, 33 U.S.C. § 901 et seq.) or the Merchant Marine Act of 1920 (41 Stat. 988, 46 U.S.C. § 861 et seq.) or persons whose employment is casual in character and not in the regular course of the business of the employer, and exclusive of persons to whom articles or materials are given out to be made up, cleaned, washed, altered, ornamented, finished or repaired, or adapted for sale in the worker's own home, or on other premises, not under the control or management of the employer. Except as hereinafter provided in clause (c) of section 302 and sections 305 and 321, every executive officer of a corporation elected or appointed in accordance with the charter and by-laws of the corporation, except elected officers of the Commonwealth or any of its political subdivisions, shall be an employe of the corporation. An executive officer of a for-profit corporation or an executive officer of a nonprofit corporation who serves voluntarily and without remuneration may, however, elect not to be an employe of the corporation for the purposes of this act. For purposes of this section, an executive officer of a for-profit corporation is an individual who has an ownership interest in the corporation, in the case of a Subchapter S corporation as defined by the act of March 4, 1971 (P.L. 6, No. 2), known as the "Tax Reform Code of 1971," or an ownership interest in the corporation of at least five per centum, in the case of a Subchapter C corporation as defined by the Tax Reform Code of 1971.

In addition to those persons included within the definition of the word "employe" as defined in section 104 of the act of June 2, 1915 (P.L. 736), known as "The Pennsylvania Workmen's Compensation Act", reenacted and amended June 21, 1939 (P.L. 520), and amended February 28, 1956 (P.L. 1120), there shall be included all auxiliary police of the various cities, boroughs, incorporated towns and townships, who shall be "employes" of such cities, boroughs, incorporated towns and townships for all the purposes of the act, and shall be entitled to receive compensation in case of injuries received while actually engaged as policemen or while going to or returning from their place of duty or while participating in instruction or while answering any emergency call for any purpose or while performing any other duty authorized by the city, borough, incorporated town or township.

The city, borough, incorporated town or township as employer shall, in all cases, be deemed to have knowledge of all other employment of all auxiliary police, including self employment, and earnings in such employment shall be included in computing average weekly wages. In all cases where an injury compensable under the provisions of this act is received by an auxiliary policeman who is, in whole or in part, a self employer and loss of earnings results therefrom, such earnings shall for the purposes of this act be regarded as wages. The average weekly wage as so regarded shall be that most favorable to the employe computed by dividing by thirteen the total earnings of the employe in the first, second, third or fourth period

of thirteen consecutive calendar weeks in the fifty-two weeks immediately preceding the accident. In all cases where an injury compensable under the provisions of this act is received by a member of the auxiliary police who is self-employed or unemployed, payments shall be made of not less than twenty-two dollars and fifty cents ($22.50) per week for total disability and not less than twelve dollars and fifty cents ($12.50) for partial disability.

In addition to those persons included within the definition of the word "employe" as defined in section 104, act of June 2, 1915 (P.L. 736), known as "The Pennsylvania Workmen's Compensation Act", reenacted and amended June 21, 1939 (P.L. 520), and amended February 28, 1956 (P.L. 1120), there shall be included all special school police in municipalities and townships, who shall be and are hereby declared to be "employes" of the appointing municipality or township for all the purposes of said act, and shall be entitled to receive compensation in case of injuries received while actually engaged as policemen or while participating in instruction or while answering any emergency call for any purpose or while performing any other duty authorized by the municipality or township.

The municipality or township as employer shall, in all cases, be deemed to have knowledge of all other employment of all members of its special school police, including self-employment, and shall be liable for compensation on account of all wages and earnings resulting therefrom. In all cases where an injury compensable under the provisions of this act is received by a member of the special school police who is, in whole or in part, a self-employer and loss of earnings results therefrom, such earnings shall, for the purposes of this act, be regarded as wages. The average weekly wage as so regarded shall be that most favorable to the employe, computed by dividing by thirteen the total earnings of the employe in the first, second, third or fourth period of thirteen consecutive calendar weeks in the fifty-two weeks immediately preceding the accident. In all cases where an injury compensable under the provisions of this act is received by a member of the special school police of a municipality or township, who is self-employed or unemployed, payments shall be made of not less than twenty-two dollars and fifty cents ($22.50) per week for total disability and not less than twelve dollars and fifty cents ($12.50) for partial disability.

Sec 105 The term "contractor," as used in article two, section two hundred and three, and article three, section three hundred and two (b), shall not include a contractor engaged in an independent business, other than that of supplying laborers or assistants, in which he serves persons other than the employer in whose service the injury occurs, but shall include a sub-contractor to whom a principal contractor has sublet any part of the work which such principal contractor has undertaken.

Sec 105.1 The term "the Statewide average weekly wage," as used in this act, means that amount which shall be determined annually by the department for each calendar year on the basis of employment covered by the Pennsylvania Unemployment Compensation Law for the twelve-month period ending June 30 preceding the calendar year.

Sec 105.2 The terms "the maximum weekly compensation payable" and "the maximum compensation payable per week," as used in this act, mean sixty-six and two-thirds per centum of "the Statewide average weekly wage" as defined in section 105.1. Effective July 1, 1975, the terms "the maximum weekly compensation payable" and "the maximum compensation payable per week" as used in this act for injuries or death after the effective date of this amendatory act shall mean the Statewide average weekly wage as defined in section 105.

Sec 105.3 The term "construction design professional," as used in this act, means a professional engineer or land surveyor licensed by the State Registration Board for Professional Engineers, Land Surveyors and Geologists under the act of May 23, 1945 (P.L. 913, No. 367), known as the "Engineer, Land Surveyor and Geologist Registration Law," a landscape architect who is licensed by the State Board of Landscape Architects under the act of January 24, 1966 (1965 P.L. 1527, No. 535), known as the "Landscape Architects' Registration Law," an architect who is licensed by the Architects Licensure Board under the act of December 14, 1982 (P.L. 1227, No. 281), known as the "Architects Licensure Law," or any corporation or association, including

professional corporations, organized or registered under the act of December 21, 1988 (P.L. 1444, No. 177), known as the "General Association Act of 1988," practicing engineering, architecture, landscape architecture or surveying in this Commonwealth.

Sec 105.4 The term "hazardous occupational noise," as used in this act, means noise levels exceeding permissible noise exposures as defined in Table G-16 of OSHA Occupational Noise Exposure Standards, 29 CFR 1910.95 (relating to occupational noise exposure) (July 1, 1994).

Sec 105.5 The term "Impairment Guides," as used in this act, means the American Medical Association's Guides to the Evaluation of Permanent Impairment, Fourth Edition (June 1993).

Sec 105.6 The term "long-term exposure," as used in this act, means exposure to noise exceeding the permissible daily exposure for at least three days each week for forty weeks of one year.

Sec 106 The exercise and performance of the powers and duties of a local or other public authority shall, for the purposes of this act, be treated as the trade or business of the authority.

Sec 107 The term "Department," when used in this act, shall mean the Department of Labor and Industry of this Commonwealth.

The term "Board," when used in this act, shall mean The Workers' Compensation Appeal Board of this Commonwealth.

Sec 108 The term "occupational disease," as used in this act, shall mean only the following diseases.

(a) Poisoning by arsenic, lead, mercury, manganese, or beryllium, their preparations or compounds, in any occupation involving direct contact with, handling thereof, or exposure thereto.

(b) Poisoning by phosphorus, its preparations or compounds, in any occupation involving direct contact with, handling thereof, or exposure thereto.

(c) Poisoning by methanol, carbon disulfide, carbon monoxide, hydrocarbon distillates (naphthas and others) or halogenated hydrocarbons, toluene diisocyanate (T.D.1.) or any preparations containing these chemicals or any of them, in any occupation involving direct contact with, handling thereof, or exposure thereto.

(d) Poisoning by benzol, or by nitro, amido, or amino derivatives of benzol (dinitro-benzol, aniline, and others), or their preparations or compounds, in any occupation involving direct contact with, handling thereof, or exposure thereto.

(e) Caisson disease (compressed air illness) resulting from engaging in any occupation carried on in compressed air.

(f) Radium poisoning or disability, due to radioactive properties of substances or to Roentgen-ray (X-rays) in any occupation involving direct contact with, handling thereof, or exposure thereto.

(g) Poisoning by, or ulceration from chronic acid, or bichromate of ammonium, bichromate of potassium, or bichromate of sodium, or their preparations, in any occupation involving direct contact with, handling thereof, or exposure thereto.

(h) Epitheliomatous cancer or ulceration due to tar, pitch, bitumen, mineral oil, or paraffin, or any compound, product or residue of any of those substances, in any occupation involving direct contact with, handling thereof, or exposure thereto.

(i) Infection or inflammation of the skin due to oils, cutting compounds, lubricants, dust, liquids, fumes, gasses, or vapor, in any occupation involving direct contact with, handling thereof, or exposure thereto.

(j) Anthrax occurring in any occupation involving the handling of, or exposure to wool, hair, bristles, hides, or skins, or bodies of animals either alive or dead.

(k) Silicosis in any occupation involving direct contact with, handling of, or exposure to the dust of silicon dioxide.

(l) Asbestosis and cancer resulting from direct contact with, handling of, or exposure to the dust of asbestos in any occupation involving such contact, handling or exposure.

(m) Tuberculosis, serum hepatitis, infectious hepatitis or hepatitis C in the occupations of blood processors, fractionators, nursing, or auxiliary services involving exposure to such diseases.

(m.1) Hepatitis C in the occupations of professional and volunteer firefighters, volunteer ambulance corps personnel, volunteer rescue and lifesaving squad personnel, emergency medical services personnel and paramedics, Pennsylvania State Police officers, police officers requiring certification under 53 Pa.C.S. Ch. 21 (relating to employees), and Commonwealth and county correctional employes, and forensic security employes of the Department of Public Welfare, having duties including care, custody and control of inmates involving exposure to such disease. Hepatitis C in any of these occupations shall establish a presumption that such disease is an occupational disease within the meaning of this act, but this presumption shall not be conclusive and may be rebutted. This presumption shall be rebutted if the employer has established an employment screening program, in accordance with guidelines established by the department in coordination with the Department of Health and the Pennsylvania Emergency Management Agency and published in the Pennsylvania Bulletin, and testing pursuant to that program establishes that the employe incurred the Hepatitis C virus prior to any job-related exposure.

(n) All other diseases (1) to which the claimant is exposed by reason of his employment, and (2) which are causally related to the industry or occupation, and (3) the incidence of which is substantially greater in that industry or occupation than in the general population. For the purposes of this clause, partial loss of hearing in one or both ears due to noise; and the diseases silicosis, anthraco-silicosis and coal workers' pneumoconiosis resulting from employment in and around a coal mine, shall not be considered occupational diseases.

(o) Diseases of the heart and lungs, resulting in either temporary or permanent total or partial disability or death, after four years or more of service in fire fighting for the benefit or safety of the public, caused by extreme over-exertion in times of stress or danger or by exposure to heat, smoke, fumes or gasses, arising directly out of the employment of any such firemen.

(p) Byssinosis in any occupation involving direct contact with, handling of, or exposure to cotton dust, cotton materials, or cotton fibers.

(q) Coal worker's pneumoconiosis, anthraco-silicosis and silicosis (also known as miner's asthma or black lung) in any occupation involving direct contact with, handling of or exposure to the dust of anthracite or bituminous coal.

(r) Cancer suffered by a firefighter which is caused by exposure to a known carcinogen which is recognized as a Group 1 carcinogen by the International Agency for Research on Cancer.

Sec 109 In addition to the definitions set forth in this article, the following words and phrases when used in this act

shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Adjudication" shall have the meaning given in 2 Pa.C.S. § 101 (relating to definitions).

"Bill" means a statement or invoice for payment of services under subsection (f.1) of section 306 which identifies the claimant, the date of injury, the payment codes referred to in subsection (f.1) of section 306 and a description of the services provided on or in standard form prescribed by the Department of Labor and Industry.

"Burn facility" means a facility which meets the service standards of the American Burn Association.

"Commissioner" means the Insurance Commissioner of the Commonwealth.

"Coordinated care organization" or "CCO" means an organization licensed in Pennsylvania and certified by the Secretary of Labor and Industry on the basis of established criteria possessing the capacity to provide medical services to an injured worker.

"DRG" means diagnosis-related groups.

"HCFA" means the Health Care Financing Administration.

"Health care provider" means any person, corporation, facility or institution licensed or otherwise authorized by the Commonwealth to provide health care services, including, but not limited to, any physician, coordinated care organization, hospital, health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, psychologist, chiropractor or pharmacist and an officer, employe or agent of such person acting in the course and scope of employment or agency related to health care services.

"Health maintenance organization" means an entity defined in and subject to the act of December 29, 1972 (P.L. 1701, No. 364), known as the "Health Maintenance Organization Act."

"Hospital plan corporation" means an entity defined in and subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).

"Insurance Company Law of 1921" means the act of May 17, 1921 (P.L. 682, No. 284), known as "The Insurance Company Law of 1921."

"Insurer" means an entity subject to the act of May 17, 1921 (P.L. 682, No. 284), known as "The Insurance Company Law of 1921," including the State Workmen's Insurance Fund, with which an employer has insured liability under this act pursuant to section 305 or a self-insured employer or fund exempted by the Department of Labor and Industry pursuant to section 305.

"Intermediary" means an organization with a contractual relationship with the Health Care Financing Administration to process Medicare Part A or Part B claims.

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

"Occupational Disease Act" means the act of June 21, 1939 (P.L. 566, No. 284), known as "The Pennsylvania Occupational Disease Act."

"Pass-through costs" means Medicare-reimbursed costs to a hospital that "pass through" the prospective payment system and are not included in the diagnosis-related group payments. The term includes medical education, capital expenditures, insurance and interest expense on fixed assets.

"Peer review," for the purpose of undertaking reviews and reports pursuant to section 420, means review by:

(1) an impartial physician or other health care provider selected by the Secretary of Labor and Industry upon recommendation of the deans of the medical colleges located in this Commonwealth;

(2) a panel of such professionals and providers selected by the Secretary of Labor and Industry upon recommendation of the deans of the medical colleges located in this Commonwealth or recommendation of professional associations representing such professionals and providers; or

(3) a Peer Review Organization approved by the commissioner and selected by the Secretary of Labor and Industry.

"Professional health service corporation" means an entity defined in and subject to 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

"Provider" means a health care provider.

"Referee" means a workers' compensation judge, as designated under section 401.

"Secretary" means the Secretary of Labor and Industry of the Commonwealth.

"Trauma center" means a facility accredited by the Pennsylvania Trauma Systems Foundation under the act of July 3, 1985 (P.L. 164, No. 45), known as the "Emergency Medical Services Act."

"Urgent injury" shall be as defined by the American College of Surgeons' triage guidelines regarding use of trauma centers for the region where the services are provided.

"Usual and customary charge" means 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.

"Utilization review organizations" shall be those organizations consisting of an impartial physician, surgeon or other health care provider or a panel of such professionals and providers as authorized by the Secretary of Labor and Industry and published as a list in the form of a notice in the Pennsylvania Bulletin for the purpose of reviewing the reasonableness and necessity of treatment by a health care provider pursuant to section 306(f.1)(6).

ARTICLE II
Damages by Action at Law

Sec 201 In any action brought to recover damages for personal injury to an employe in the course of his employment, or for death resulting from such injury, it shall not be a defense—

(a) That the injury was caused in whole or in part by the negligence of a fellow employe; or

(b) That the employe had assumed the risk of the injury; or

(c) That the injury was caused in any degree by the negligence of such employe, unless it be established that the injury was caused by such employe's intoxication or by his reckless indifference to danger. The burden of proving such intoxication or reckless indifference to danger shall be upon the defendant, and the question shall be one of fact to be determined by the jury.

Sec 202 The employer shall be liable for the negligence of all employes, while acting within the scope of their employment, including engineers, chauffeurs, miners, mine-foremen, fire-bosses, mine superintendents, plumbers, officers of vessels, and all other employes licensed by the Commonwealth or other governmental authority, if the employer be allowed by law the right of free selection of such employes from the class of persons thus licensed; and such employes shall be the agents and representatives of their employers and their employers shall be responsible for the acts and neglects of such employes, as in the case of other agents and employes of their employers; and, notwithstanding the employment of such employes, the property in and about which they are employed, and the use and operation thereof, shall at all times be under the supervision, management and control of their employers.

Sec 203 An employer who permits the entry upon premises occupied by him or under his control of a laborer or an assistant hired by an employe or contractor, for the performance upon such premises of a part of the employer's regular business entrusted to such employe or contractor, shall be liable to such laborer or assistant in the same manner and to the same extent as to his own employe.

Sec 204 (a) No agreement, composition, or release of damages made before the date of any injury shall be valid or shall bar a claim for damages resulting therefrom; and any such agreement is declared to be against the public policy of this Commonwealth. The receipt of benefits from any association, society, or fund shall not bar the recovery of damages by action at law, nor the recovery of compensation under article three hereof; and any release executed in consideration of such benefits shall be void: Provided, however, That if the employe receives unemployment compensation benefits, such amount or amounts so received shall be credited as against the amount of the award made under the provisions of sections 108 and 306, except for benefits payable under section 306(c) or 307. Fifty per centum of the benefits commonly characterized as "old age" benefits under the Social Security Act (49 Stat. 620, 42 U.S.C. § 301 et seq.) shall also be credited against the amount of the payments made under sections 108 and 306, except for benefits payable under section 306(c): Provided, however, That the Social Security offset shall not apply if old age Social Security benefits were received prior to the compensable injury. The severance benefits paid by the employer directly liable for the payment of compensation and the benefits from a pension plan to the extent funded by the employer directly liable for the payment of compensation which are received by an employe shall also be credited against the amount of the award made under sections 108 and 306, except for benefits payable under section 306(c). The employe shall provide the insurer with proper authorization to secure the amount which the employe is receiving under the Social Security Act.

(b) For the exclusive purpose of determining eligibility for compensation under the act of December 5, 1936 (2nd Sp. Sess., 1937 P.L. 2897, No.1), known as the "Unemployment Compensation Law," any employe who does not meet the monetary and credit week requirements under section 401(a) of that act due to a work-related injury compensable under this act may elect to have his base year consist of

the four complete calendar quarters immediately preceding the date of the work-related injury.

(c) The employe is required to report regularly to the insurer the receipt of unemployment compensation benefits, wages received in employment or self-employment, benefits commonly characterized as "old age" benefits under the Social Security Act, severance benefits and pension benefits, which post-date the compensable injury under this act, subject to the fraud provisions of Article XI.

(d) The department shall prepare the forms necessary for the enforcement of this section and issue rules and regulations as appropriate.

Sec 205 If disability or death is compensable under this act, a person shall not be liable to anyone at common law or otherwise on account of such disability or death for any act or omission occurring while such person was in the same employ as the person disabled or killed, except for intentional wrong.

ARTICLE III
Liability and Compensation

Sec 301 (a) Every employer shall be liable for compensation for personal injury to, or for the death of each employe, by an injury in the course of his employment, and such compensation shall be paid in all cases by the employer, without regard to negligence, according to the schedule contained in sections three hundred and six and three hundred and seven of this article: Provided, That no compensation shall be paid when the injury or death is intentionally self inflicted, or is caused by the employe's violation of law, including, but not limited to, the illegal use of drugs, but the burden of proof of such fact shall be upon the employer, and no compensation shall be paid if, during hostile attacks on the United States, injury or death of employes results solely from military activities of the armed forces of the United States or from military activities or enemy sabotage of a foreign power. In cases where the injury or death is caused by intoxication, no compensation shall be paid if the injury or death would not have occurred but for the employe's intoxication, but the burden of proof of such fact shall be upon the employer.

(b) The right to receive compensation under this act shall not be affected by the fact that a minor is employed or is permitted to be employed in violation of the laws of this Commonwealth relating to the employment of minors, or that he obtained his employment by misrepresenting his age.

(c) (1) The terms "injury" and "personal injury," as used in this act, shall be construed to mean an injury to an employe, regardless of his previous physical condition, except as provided under subsection (f), arising in the course of his employment and related thereto, and such disease or infection as naturally results from the injury or is aggravated, reactivated or accelerated by the injury; and wherever death is mentioned as a cause for compensation under this act, it shall mean only death resulting from such injury and its resultant effects, and occurring within three hundred weeks after the injury. The term "injury arising in the course of his employment," as used in this article, shall not include an injury caused by an act of a third person intended to injure the employe because of reasons personal to him, and not directed against him as an employe or because of his employment; nor shall it include injuries sustained while the employe is operating a motor vehicle provided by the employer if the employe is not otherwise in the course of employment at the time of injury; but shall include all other injuries sustained while the employe is actually engaged in the furtherance of the business or affairs of the employer, whether upon the employer's premises or elsewhere, and shall include all injuries caused by the condition of the premises or by the operation of the employer's business or affairs thereon, sustained by the employe, who, though not so engaged, is injured upon the premises occupied by or under the control of the employer, or upon which the employer's business or affairs are being carried on, the employe's presence thereon being required by the nature of his employment.

(2) The terms "injury," "personal injury," and "injury arising in the course of his employment," as used in this act, shall include, unless the context clearly requires otherwise, occupational disease as defined in section 108 of this act: Provided, That whenever occupational disease is the basis for compensation, for disability or death under this act, it shall apply only to disability or death resulting from such disease and occurring within three hundred weeks after the last date of employment in an occupation or industry to which he was exposed to hazards of such disease: And provided further, That if the employe's compensable disability has occurred within such period, his subsequent death as a result of the disease shall likewise be compensable. The provisions of this paragraph (2) shall apply only with respect to the disability or death of an employe which results in whole or in part from the employe's exposure to the hazard of occupational disease after June 30, 1973 in employment covered by The Pennsylvania Workmen's Compensation Act. The employer liable for compensation provided by section 305.1 or section 108, subsections (k), (l), (m), (o), (p), (q) or (r), shall be the employer in whose

employment the employe was last exposed for a period of not less than one year to the hazard of the occupational disease claimed. In the event the employe did not work in an exposure at least one year for any employer during the three hundred week period prior to disability or death, the employer liable for the compensation shall be that employer giving the longest period of employment in which the employe was exposed to the hazards of the disease claimed.

(d) Compensation for silicosis, anthraco-silicosis, coal worker's pneumoconiosis or asbestosis, shall be paid only when it is shown that the employe has had an aggregate employment of at least two years in the Commonwealth of Pennsylvania, during a period of ten years next preceding the date of disability, in an occupation having a silica, coal or asbestos hazard.

(e) If it be shown that the employe, at or immediately before the date of disability, was employed in any occupation or industry in which the occupational disease is a hazard, it shall be presumed that the employe's occupational disease arose out of and in the course of his employment, but this presumption shall not be conclusive.

(f) Compensation pursuant to cancer suffered by a firefighter shall only be to those firefighters who have served four or more years in continuous firefighting duties, who can establish direct exposure to a carcinogen referred to in section 108(r) relating to cancer by a firefighter and have successfully passed a physical examination prior to asserting a claim under this subsection or prior to engaging in firefighting duties and the examination failed to reveal any evidence of the condition of cancer. The presumption of this subsection may be rebutted by substantial competent evidence that shows that the firefighter's cancer was not caused by the occupation of firefighting. Any claim made by a member of a volunteer fire company shall be based on evidence of direct exposure to a carcinogen referred to in section 108(r) as documented by reports filed pursuant to the Pennsylvania Fire Information Reporting System and provided that the member's claim is based on direct exposure to a carcinogen referred to in section 108(r). Notwithstanding the limitation under subsection (c)(2) with respect to disability or death resulting from an occupational disease having to occur within three hundred weeks after the last date of employment in an occupation or industry to which a claimant was exposed to the hazards of disease, claims filed pursuant to cancer suffered by the firefighter under section 108(r) may be made within six hundred weeks after the last date of employment in an occupation or industry to which a claimant was exposed to the hazards of disease. The presumption provided for under this subsection shall only apply to claims made within the first three hundred weeks.

Sec 302 (a) A contractor who subcontracts all or any part of a contract and his insurer shall be liable for the payment of compensation to the employes of the subcontractor unless the subcontractor primarily liable for the payment of such compensation has secured its payment as provided for in this act. Any contractor or his insurer who shall become liable hereunder for such compensation may recover the amount thereof paid and any necessary expenses from the subcontractor primarily liable therefor.

For purposes of this subsection, a person who contracts with another (1) to have work performed consisting of (i) the removal, excavation or drilling of soil, rock or minerals, or (ii) the cutting or removal of timber from lands, or (2) to have work performed of a kind which is a regular or recurrent part of the business, occupation, profession or trade of such person shall be deemed a contractor, and such other person a subcontractor. This subsection shall not apply, however, to an owner or lessee of land principally used for agriculture who is not a covered employer under this act and who contracts for the removal of timber from such land.

(b) Any employer who permits the entry upon premises occupied by him or under his control of a laborer or an assistant hired by an employe or contractor, for the performance upon such premises of a part of such employer's regular business entrusted to that employe or contractor, shall be liable for the payment of compensation to such laborer or assistant unless such hiring employe or contractor, if primarily liable for the payment of such compensation, has secured the payment thereof as provided

for in this act. Any employer or his insurer who shall become liable hereunder for such compensation may recover the amount thereof paid and any necessary expenses from another person if the latter is primarily liable therefor.

For purposes of this subsection (b), the term "contractor" shall have the meaning ascribed in section 105 of this act.

(c) Any employer employing persons in agricultural labor shall be required to provide workmen's compensation coverage for such employes according to the provisions of this act, if such employer is otherwise covered by the provisions of this act or if during the calendar year such employer pays wages to one employe for agricultural labor totaling one thousand two hundred dollars ($1,200) or more or furnishes employment to one employe in agricultural labor on thirty or more days in any of which events the employer shall be required to provide coverage for all employes. For purposes of this clause, a spouse or a child of the employer under eighteen years of age shall not be deemed an employe unless the services of such spouse or child are engaged by the employer under an express written contract of hire which is filed with the department.

(d) A contractor shall not subcontract all or any part of a contract unless the subcontractor has presented proof of insurance under this act.

(e) (1) Prior to issuing a building permit to a contractor, a municipality shall require the contractor to present proof of workers' compensation insurance or an affidavit that the contractor does not employ other individuals and is not required to carry workers' compensation insurance.

(2) Every building permit issued by a municipality to a contractor shall clearly set forth the name and workers' compensation policy and the contractor's Federal or State Employer Identification Number. This information shall be in addition to any information required by municipal ordinance. If the building permit is issued to an applicant which affirms it is not obligated to maintain workers' compensation insurance under this act, the permit shall clearly set forth the contractor's Federal or State Employer Identification Number and the substance of the affirmation and that the applicant is not permitted to employ any individual to perform work pursuant to the building permit.

(3) Every municipality issuing a building permit shall be named as a workers' compensation policy certificate holder of a contractor-issued building permit. This certificate shall be filed with the municipality's copy of the building permit. An insurer issuing a policy which names a municipality as a workers' compensation policy certificate holder pursuant to this section shall be required to notify that municipality of the expiration or cancellation of any such policy of insurance or policy certificate within three working days of such cancellation or expiration.

(4) A municipality shall issue a stop-work order to a contractor who is performing work pursuant to a building permit, upon receiving actual notice that the contractor's workers' compensation insurance or State-approved self-insured status has been cancelled. Also, if the municipality receives actual notice that a permittee, having filed an affidavit of exemption from workers' compensation insurance, has hired persons to perform work pursuant to a building permit and does not maintain required workers' compensation insurance, the municipality shall issue a stop-work order. This order shall remain in effect until proper workers' compensation coverage is obtained for all work perfumed pursuant to the building permit.

(f) (1) Where a contractor is performing work for a public body or political subdivision, all contractors and subcontractors shall provide proof of workers' compensation insurance to the public body or political subdivision effective for the duration of the work.

(2) The public body or political subdivision shall issue a stop-work order to any contractor who is performing work for that public body or political subdivision upon receiving notice that any public contractor's workers' compensation insurance, or State-approved self-insurance status, has expired or has been cancelled. If the public body or political subdivision receives actual notice that a contractor, having filed an affidavit of exemption from workers' compensation insurance, has hired persons to perform work for a public body or political subdivision and does not maintain the required workers' compensation insurance or self-insurance, the public body or political subdivision shall issue a stop-work order, which order shall remain in effect until proper workers' compensation coverage is obtained for all work performed pursuant to the contract of work for the public body or political subdivision.

(g) Should such policy of workers' compensation insurance be cancelled or expire during the duration of the work or should the workers' compensation self-insurance status change during the said period, the contractor shall immediately notify, in writing, the municipality, public body or political subdivision of such cancellation, expiration or change in status.

(h) Nothing in this act shall be the basis of any liability on part of the municipality.

(i) For purposes of subsections (d), (e) and (f), "proof of insurance" shall include a certificate of insurance or self-insurance, demonstrating current coverage and compliance with the requirements of this act, the Occupational Disease Act and the Longshore and Harbor Workers' Compensation Act (44 Stat. 1424, 33 U.S.C. § 901 et seq.), its amendments and supplements, where applicable.

(j) For purposes of subsections (d), (e) and (f), "proof of insurance" shall not be required when the employer has been exempted pursuant to section 304.2.

Sec 303 (a) The liability of an employer under this act shall be exclusive and in place of any and all other liability to such employes, his legal representative, husband or wife, parents, dependents, next of kin or anyone otherwise entitled to damages in any action at law or otherwise on account of any injury or death as defined in section 301(c)(1) and (2) or occupational disease as defined in section 108.

(b) In the event injury or death to an employe is caused by a third party, then such employe, his legal representative, husband or wife, parents, dependents, next of kin, and anyone otherwise entitled to receive damages by reason thereof, may bring their action at law against such third party, but the employer, his insurance carrier, their servants and agents, employes, representatives acting on their behalf or at their request shall not be liable to a third party for damages, contribution, or indemnity in any action at law, or otherwise, unless liability for such damages, contributions or indemnity shall be expressly provided for in a written contract entered into by the party alleged to be liable prior to the date of the occurrence which gave rise to the action.

Sec 304.2 (a) An employer may file an application with the Department of Labor and Industry to be excepted from the provisions of this act in respect to certain employes. The application shall include a written waiver by the employe of all benefits under the act and an affidavit by the employe that he is a member of a recognized religious sect or division thereof and is an adherent of established tenets or teachings of such sect or division by reason of which he is conscientiously opposed to acceptance of the benefits of any public or private insurance which makes payments in the event of death, disability, old age or retirement or makes payments toward the cost of, or provides services for medical bills (including the benefits of any insurance system established by the Federal Social Security Act 42 U.S.C. 301 et seq.).

(b) The waiver and affidavit required by subsection (a) shall be made upon a form to be provided by the Department of Labor and Industry.

(c) Such application shall be granted if the Department of Labor and Industry shall find that (i) the employe is a member of a sect or division having the established tenets or teachings referred to in subsection (a); (ii) it is the practice, and has been for a substantial number of years, for members of such sect or division thereof to make provision for their dependent members which in its judgment is reasonable in view of their general level of living. Receipt of a form required by subsection (b) shall be considered prima facie proof that this subsection has been complied with.

(d) When an employe is a minor, the waiver and affidavit required by subsection (a) may be made by guardian of the minor.

(e) An exception granted in regard to a specific employe shall be valid for all future years unless such employe or sect ceases to meet the requirements of subsection (a).

Sec 305 (a) (1) Every employer liable under this act to pay compensation shall insure the payment of compensation in the State Workmen's Insurance Fund, or in any insurance company, or mutual association or company, authorized to insure such liability in this Commonwealth, unless such employer shall be exempted by the department from such insurance. Such insurer shall assume the employer's liability hereunder and shall be entitled to all of the employer's immunities and protection hereunder except, that whenever any employer shall have purchased insurance to provide benefits under this act to persons engaged in domestic service, neither the employer nor the insurer may invoke the provisions of section 321 as a defense. An employer desiring to be exempt from insuring the whole or any part of his liability for compensation shall make application to the department, showing his financial ability to pay such compensation, whereupon the department, if satisfied of the applicant's financial ability, shall, upon the payment of a fee of five hundred dollars ($500), issue to the applicant a permit authorizing such exemption.

(2) In securing the payment of benefits, the department shall require an employer wishing to self-insure its liability and a group of employers approved to pool their liabilities under Article VIII to establish sufficient security by posting a bond or other security, including letters of credit drawn on commercial banks with a Thomson Bank Watch rating of B/C or better or a Thomson Bank Watch score of 2.5 or better for the bank or its holding company or with a CD rating of BBB or better by Standard and Poor's. This paragraph shall not apply to the Commonwealth or its political subdivisions.

(3) The department shall establish a period of twelve (12) calendar months, to begin and end at such times as the department shall prescribe, which shall be known as the annual exemption period. Unless previously revoked, all permits issued under this section shall expire and terminate on the last day of the annual exemption period for which they were issued. Permits issued under this act shall be renewed upon the filing of an application, and the payment of a renewal fee of one hundred dollars ($100.00). The department may, from time to time, require further statements of the financial ability of such employer, and, if at any time such employer appear no longer able to pay compensation, shall revoke its permit granting exemption, in which case the employer shall immediately subscribe to the State Workmen's Insurance Fund, or insure his liability in any insurance company or mutual association or company, as aforesaid.

(b) Any employer who fails to comply with the provisions of this section for every such failure, shall, upon conviction in the court of common pleas, be guilty of a misdemeanor of the third degree. If the failure to comply with this section is found by the court to be intentional, the employer shall be guilty of a felony of the third degree. Every day's violation shall constitute a separate offense. A judge of the court of common pleas may, in addition to imposing fines and imprisonment, include restitution in his order: Provided, That there is an injured employe who has obtained an award of compensation. The

amount of restitution shall be limited to that specified in the award of compensation. It shall be the duty of the department to enforce the provisions of this section; and it shall investigate all violations that are brought to its notice and shall institute prosecutions for violations thereof. All fines recovered under the provisions of this section shall be paid to the department, and by it paid into the State Treasury and appropriated to the Office of Attorney General if the prosecutor is the Attorney General and paid to the operating fund of the county in which the district attorney is elected if the prosecutor is a district attorney.

(c) In any proceeding against an employer under this section, a certificate of non-insurance issued by the official Workmen's Compensation Rating and Inspection Bureau and a certificate of the department showing that the defendant has not been exempted from obtaining insurance under this section, shall be prima facie evidence of the facts therein stated.

(d) When any employer fails to secure the payment of compensation under this act as provided in sections 305 and 305.2, the injured employe or his dependents may proceed either under this act or in a suit for damages at law as provided by article II.

(e) Every employer shall post a notice at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employes or for the administration of first aid, containing:

(1) Either the name of the employer's carrier and the address and telephone number of such carrier or insurer or, if the employer is self-insured, the name, address and telephone number of the person to whom claims or requests for information are to be addressed.

(2) The following statement: "Remember, it is important to tell your employer about your injury."

The notice shall be posted in prominent and easily accessible places at the site of employment, including such places as are used for treatment and first aid of injured employes. Such a listing shall contain the information as specified in this section, typed or printed on eight and one-half inch by eleven inch or eight and one-half inch by thirteen inch paper in standard size type or larger.

Sec 305.1 Any compensation payable under this act for silicosis, anthraco-silicosis or coal-worker's pneumoconiosis as defined in section 108(q) for disability occurring on or after July 1, 1973 or for death resulting therefrom shall be paid as follows: if the disability begins between July 1, 1973 and June 30, 1974, inclusive, the employer shall pay twenty-five per centum and the Commonwealth seventy-five per centum; if the disability begins between July 1, 1974, and June 30, 1975, inclusive, the employer shall pay fifty per centum and the Commonwealth fifty per centum; if the disability begins between July 1, 1975 and June 30, 1976, inclusive, the employer shall pay seventy-five per centum and the Commonwealth twenty-five per centum; and if the disability begins on or after July l, 1976, all compensation shall be payable by the employer. The procedures for payment of compensation in such cases shall be as prescribed in the rules and regulations of the department.

Sec 305.2 (a) If an employe, while working outside the territorial limits of this State, suffers an injury on account of which he, or in the event of his death, his dependents, would have been entitled to the benefits provided by this act had such injury occurred within this State, such employe, or in the event of his death resulting from such injury, his dependents, shall be entitled to the benefits provided by this act, provided that at the time of such injury:

(1) His employment is principally localized in this State, or

(2) He is working under a contract of hire made in this State in employment not principally localized in any state, or

(3) He is working under a contract of hire made in this State in employment principally localized in another state whose workmen's compensation law is not applicable to his employer, or

(4) He is working under a contract of hire made in this State for employment outside the United States and Canada.

(b) The payment or award of benefits under the workmen's compensation law of another state, territory, province or foreign nation to an employe or his dependents otherwise entitled on account of such injury or death to the benefits of this act shall not be a bar to a claim for benefits under this act; provided that claim under this act is filed within three years after such injury or death. If compensation is paid or awarded under this act:

(1) The medical and related benefits furnished or paid for by the employer under such other workmen's compensation law on account of such injury or death shall be credited against the medical and related benefits to which the employe would have been entitled under this act had claim been made solely under this act.

(2) The total amount of all income benefits paid or awarded the employe under such other workmen's compensation law shall be credited against the total amount of income benefits which would have been due the employe under this act, had claim been made solely under this act.

(3) The total amount of death benefits paid or awarded under such other workmen's compensation law shall be credited against the total amount of death benefits due under this act.

Nothing in this act shall be construed to mean that coverage under this act excludes coverage under another law or that an employe's election to claim compensation under this act is exclusive of coverage under another state act or is binding on the employe or dependent, except, perhaps to the extent of an agreement between the employe and the employer or where employment is localized to the extent that an employe's duties require him to travel regularly in this State and another state or states.

(c) If an employe is entitled to the benefits of this act by reason of an injury sustained in this State in employment by an employer who is domiciled in another state and who has not secured the payment of compensation as required by this act, the employer or his carrier may file with the director a certificate, issued by the commission or agency of such other state having jurisdiction over workmen's compensation claims, certifying that such employer has secured the payment of compensation under the workmen's compensation law of such other state and that with respect to said injury such employe is entitled to the benefits provided under such law.

In such event:

(1) The filing of such certificate shall constitute an appointment by such employer or his carrier of the Secretary of Labor and Industry as his agent for acceptance of the service of process in any proceeding brought by such employe or his dependents to enforce his or their rights under this act on account of such injury;

(2) The secretary shall send to such employer or carrier, by registered or certified mail to the address shown on such certificate, a true copy of any notice of claim or other process served on the secretary by the employe or his dependents in any proceeding brought to enforce his or their rights under this act;

(3) (i) If such employer is a qualified self-insurer under the workmen's compensation law of

such other state, such employer shall, upon submission of evidence, satisfactory to the director, of his ability to meet his liability to such employe under this act, be deemed to be a qualified self-insurer under this act;

(ii) If such employer's liability under the workmen's compensation law of such other state is insured, such employer's carrier, as to such employe or his dependents only, shall be deemed to be an insurer authorized to write insurance under and be subject to this act: Provided, however, That unless its contract with said employer requires it to pay an amount equivalent to the compensation benefits provided by this act, its liability for income benefits or medical and related benefits shall not exceed the amounts of such benefits for which such insurer would have been liable under the workmen's compensation law of such other state;

(4) If the total amount for which such employer's insurance is liable under clause (3) above is less than the total of the compensation benefits to which such employe is entitled under this act, the secretary may, if he deems it necessary, require the employer to file security, satisfactory to the secretary, to secure the payment of benefits due such employe or his dependents under this act; and

(5) Upon compliance with the preceding requirements of this subsection (c), such employer, as to such employe only, shall be deemed to have secured the payment of compensation under this act.

(d) As used in this section:

(1) "United States" includes only the states of the United States and the District of Columbia.

(2) "State" includes any state of the United States, the District of Columbia, or any Province of Canada.

(3) "Carrier" includes any insurance company licensed to write workmen's compensation insurance in any state of the United States or any state or provincial fund which insures employers against their liabilities under a workmen's compensation law.

(4) A person's employment is principally localized in this or another state when (i) his employer has a place of business in this or such other state and he regularly works at or from such place of business, or (ii) having worked at or from such place of business, his duties have required him to go outside of the State not over one year, or (iii) if clauses (1) and (2) foregoing are not applicable, he is domiciled and spends a substantial part of his working time in the service of his employer in this or such other state.

(5) An employe whose duties require him to travel regularly in the service of his employer in this and one or more other states may, by written agreement with his employer, provide that his employment is principally localized in this or another such state, and, unless such other state refuses jurisdiction, such agreement shall be given effect under this act.

(6) "Workmen's compensation law" includes "occupational disease law."

Sec 306 The following schedule of compensation is hereby established:

(a) (1) For total disability, sixty-six and two-thirds per centum of the wages of the injured employe as defined in section 309 beginning after the seventh day of total disability, and payable for the duration of total disability, but the compensation shall not be more than the maximum

compensation payable as defined in section 105.2. Nothing in this clause shall require payment of compensation after disability shall cease. If the benefit so calculated is less than fifty per centum of the Statewide average weekly wage, then the benefit payable shall be the lower of fifty per centum of the Statewide average weekly wage or ninety per centum of the worker's average weekly wage.

(2) Nothing in this act shall require payment of total disability compensation benefits under this clause for any period during which the employe is employed or receiving wages.

(a.1) Nothing in this act shall require payment of compensation under clause (a) or (b) for any period during which the employe is incarcerated after a conviction or during which the employe is employed and receiving wages equal to or greater than the employe's prior earnings.

(a.2) (1) When an employe has received total disability compensation pursuant to clause (a) for a period of one hundred four weeks, unless otherwise agreed to, the employe shall be required to submit to a medical examination which shall be requested by the insurer within sixty days upon the expiration of the one hundred four weeks to determine the degree of impairment due to the compensable injury, if any. The degree of impairment shall be determined based upon an evaluation by a physician who is licensed in this Commonwealth, who is certified by an American Board of Medical Specialties approved board or its osteopathic equivalent and who is active in clinical practice for at least twenty hours per week, chosen by agreement of the parties, or as designated by the department, pursuant to the most recent edition of the American Medical Association "Guides to the Evaluation of Permanent Impairment."

(2) If such determination results in an impairment rating that meets a threshold impairment rating that is equal to or greater than fifty per centum impairment under the most recent edition of the American Medical Association "Guides to the Evaluation of Permanent Impairment," the employe shall be presumed to be totally disabled and shall continue to receive total disability compensation benefits under clause (a). If such determination results in an impairment rating less than fifty per centum impairment under the most recent edition of the American Medical Association "Guides to the Evaluation of Permanent Impairment," the employe shall then receive partial disability benefits under clause (b): Provided, however, That no reduction shall be made until sixty days' notice of modification is given.

(3) Unless otherwise adjudicated or agreed to based upon a determination of earning power under clause (b)(2), the amount of compensation shall not be affected as a result of the change in disability status and shall remain the same. An insurer or employe may, at any time prior to or during the five hundred-week period of partial disability, show that the employe's earning power has changed.

(4) An employe may appeal the change to partial disability at any time during the five hundred-week period of partial disability; Provided, That there is a determination that the employe meets the threshold impairment rating that is equal to or greater than fifty per centum impairment under the most recent edition of the American Medical Association "Guides to the Evaluation of Permanent Impairment."

(5) Total disability shall continue until it is adjudicated or agreed under clause (b) that total disability has ceased or the employe's condition improves to an impairment rating that is less than fifty per centum of the degree of impairment defined under the most recent edition of the American Medical Association "Guides to the Evaluation of Permanent Impairment."

(6) Upon request of the insurer, the employe shall submit to an independent medical examination in accordance with the provisions of section 314 to determine the status of impairment:

Provided, however, That for purposes of this clause, the employe shall not be required to submit to more than two independent medical examinations under this clause during a twelve-month period.

(7) In no event shall the total number of weeks of partial disability exceed five hundred weeks for any injury or recurrence thereof, regardless of the changes in status in disability that may occur. In no event shall the total number of weeks of total disability exceed one hundred four weeks for any employe who does not meet a threshold impairment rating that is equal to or greater than fifty per centum impairment under the most recent edition of the American Medical Association "Guides to the Evaluation of Permanent Impairment" for any injury or recurrence thereof.

(8) (i) For purposes of this clause, the term "impairment" shall mean an anatomic or functional abnormality or loss that results from the compensable injury and is reasonably presumed to be permanent.

(ii) For purposes of this clause, the term "impairment rating" shall mean the percentage of permanent impairment of the whole body resulting from the compensable injury. The percentage rating for impairment under this clause shall represent only that impairment that is the result of the compensable injury and not for any preexisting work-related or nonwork-related impairment.

(b) (1) For disability partial in character caused by the compensable injury or disease (except the particular cases mentioned in clause (c)) sixty-six and two-thirds per centum of the difference between the wages of the injured employe, as defined in section 309, and the earning power of the employe thereafter; but such compensation shall not be more than the maximum compensation payable. This compensation shall be paid during the period of such partial disability except as provided in clause (e) of this section, but for not more than five hundred weeks. Should total disability be followed by partial disability, the period of five hundred weeks shall not be reduced by the number of weeks during which compensation was paid for total disability. The term "earning power," as used in this section, shall in no case be less than the weekly amount which the employe receives after the injury; and in no instance shall an employe receiving compensation under this section receive more in compensation and wages combined than the current wages of a fellow employe in employment similar to that in which the injured employe was engaged at the time of the injury.

(2) "Earning power" shall be determined by the work the employe is capable of performing and shall be based upon expert opinion evidence which includes job listings with agencies of the department, private job placement agencies and advertisements in the usual employment area. Disability partial in character shall apply if the employe is able to perform his previous work or can, considering the employe's residual productive skill, education, age and work experience, engage in any other kind of substantial gainful employment which exists in the usual employment area in which the employe lives within this Commonwealth. If the employe does not live in this Commonwealth, then the usual employment area where the injury occurred shall apply. If the employer has a specific job vacancy the employe is capable of performing, the employer shall offer such job to the employe. In order to accurately assess the earning power of the employe, the insurer may require the employe to submit to an interview by a vocational expert who is selected by the insurer and who meets the minimum qualifications established by the department through regulation. The vocational expert shall comply with the Code of Professional Ethics for Rehabilitation Counselors pertaining to the conduct of expert witnesses.

(2.1) If an insurer refers an employe for an earning power assessment and the insurer has a

financial interest with the person or in the entity that receives the referral, the insurer shall disclose that financial interest to the employe prior to the referral.

(3) If the insurer receives medical evidence that the claimant is able to return to work in any capacity, then the insurer must provide prompt written notice, on a form prescribed by the department, to the claimant, which states all of the following:

(i) The nature of the employe's physical condition or change of condition.

(ii) That the employe has an obligation to look for available employment.

(iii) That proof of available employment opportunities may jeopardize the employe's right to receipt of ongoing benefits.

(iv) That the employe has the right to consult with an attorney in order to obtain evidence to challenge the insurer's contentions.

(c) For all disability resulting from permanent injuries of the following classes, the compensation shall be exclusively as follows:

(1) For the loss of a hand, sixty-six and two-thirds per centum of wages during three hundred thirty-five weeks.

(2) For the loss of a forearm, sixty-six and two-thirds per centum of wages during three hundred seventy weeks.

(3) For the loss of an arm, sixty-six and two-thirds per centum of wages during four hundred ten weeks.

(4) For the loss of a foot, sixty-six and two-thirds per centum of wages during two hundred fifty weeks.

(5) For the loss of a lower leg, sixty-six and two thirds per centum of wages during three hundred fifty weeks.

(6) For the loss of a leg, sixty-six and two-thirds per centum of wages during four hundred ten weeks.

(7) For the loss of an eye, sixty-six and two-thirds per centum of wages during two hundred seventy-five weeks.

(8) (i) For permanent loss of hearing which is medically established as an occupational hearing loss caused by long-term exposure to hazardous occupational noise, the percentage of impairment shall be calculated by using the binaural formula provided in the Impairment Guides. The number of weeks for which compensation shall be payable shall be determined by multiplying the percentage of binaural hearing impairment as calculated under the Impairment Guides by two hundred sixty weeks. Compensation payable shall be sixty-six and two-thirds per centum of wages during this number of weeks, subject to the provisions of clause (1) of subsection (a) of this section.

(ii) For permanent loss of hearing not caused by long-term exposure to hazardous occupational noise which is medically established to be due to other occupational causes such as acoustic trauma or head injury, the percentage of hearing impairment

shall be calculated by using the formulas as provided in the Impairment Guides. The number of weeks for which compensation shall be payable for such loss of hearing in one ear shall be determined by multiplying the percentage of impairment by sixty weeks. The number of weeks for which compensation shall be payable for such loss of hearing in both ears shall be determined by multiplying the percentage of impairment by two hundred sixty weeks. Compensation payable shall be sixty-six and two-thirds per centum of wages during this number of weeks, subject to the provisions of clause (1) of subsection (a) of this section.

(iii) Notwithstanding the provisions of subclauses (i) and (ii) of this clause, if there is a level of binaural hearing impairment as calculated under the Impairment Guides which is equal to or less than ten per centum, no benefits shall be payable. Notwithstanding the provisions of subclauses (i) and (ii) of this clause, if there is a level of binaural hearing impairment as calculated under the Impairment Guides which is equal to or more than seventy-five per centum, there shall be a presumption that the hearing impairment is total and complete, and benefits shall be payable for two hundred sixty weeks.

(iv) The percentage of hearing impairment for which compensation may be payable shall be established solely by audiogram. The audiometric testing must conform to OSHA Occupational Noise Exposure Standards, 29 CFR 1910.95 (relating to occupational noise exposure) and Appendices C, D and E to Part 1910.95 (July 1, 1994).

(v) If an employe has previously received compensation under subclause (i) or (ii) of this clause, he may receive additional compensation under subclause (i) or (ii) of this clause for any work-related increase in hearing impairment which occurred after the date of any previous award of or agreement for compensation and only if the increase in hearing impairment is ten percentage points greater than the previous compensated impairment. Any employe who has claimed a complete loss of hearing prior to the effective date of this clause and has received an award or payment for hearing loss shall be barred from claiming compensation for hearing loss or receiving payment therefor pursuant to subclause (i) or (ii) of this clause.

(vi) An employer shall be liable only for the hearing impairment caused by such employer. If previous occupational hearing impairment or hearing impairment from nonoccupational causes is established at or prior to the time of employment, the employer shall not be liable for the hearing impairment so established whether or not compensation has previously been paid or awarded.

(vii) An employer may require an employe to undergo audiometric testing at the expense of the employer from time to time. If an employer chooses to require an employe to undergo audiometric testing, the employer shall be required to notify the employe in writing that unless the employe submits to audiometric testing at the expense of and at the request of the employer the employe shall lose the right to pursue a claim for occupational hearing loss against that employer. Any employe who undergoes audiometric testing at the direction of an employer may request a copy and a brief explanation of the results which shall be provided to the employe within thirty days of the date they are available.

(viii) Whenever an occupational hearing loss caused by long-term exposure to hazardous occupational noise is the basis for compensation or additional compensation, the claim shall be barred unless a petition is filed within three years after the date of last exposure to hazardous occupational noise in the employ of the employer against whom benefits are sought.

(ix) The date of injury for occupational hearing loss under subclause (i) of this clause shall be the earlier of the date on which the claim is filed or the last date of long-term exposure to hazardous occupational noise while in the employ of the employer against whom the claim is filed.

(x) Whether the employe has been exposed to hazardous occupational noise or has long-term exposure to such noise shall be affirmative defenses to a claim for occupational hearing loss and not a part of the claimant's burden of proof in a claim.

(xi) The healing period provided for under clause (25) of this subsection shall not be applicable to any hearing loss under subclause (i) or (ii) of this clause.

(9) For the loss of a thumb, sixty-six and two-thirds per centum of wages during one hundred weeks.

(10) For the loss of a first finger, commonly called index finger, sixty-six and two-thirds per centum of wages during fifty weeks.

(11) For the loss of a second finger, sixty-six and two-thirds per centum of wages during forty weeks.

(12) For the loss of a third finger, sixty-six and two thirds per centum of wages during thirty weeks.

(13) For the loss of a fourth finger, commonly called little finger, sixty-six and two-thirds per centum of wages during twenty-eight weeks.

(14) The loss of the first phalange of the thumb shall be considered the loss of the thumb. The loss of a substantial part of the first phalange of the thumb shall be considered the loss of one-half of the thumb.

(15) The loss of any substantial part of the first phalange of a finger, or an amputation immediately below the first phalange for the purpose of providing an optimum surgical result, shall be considered loss of one-half of the finger. Any greater loss shall be considered the loss of the entire finger.

(16) The loss of one-half of the thumb, or a finger, shall be compensated at the same rate as for the loss of a thumb or finger but for one-half of the period provided for the loss of a thumb or finger.

For the loss of, or permanent loss of the use of, any two or more such members, not constituting total disability, sixty-six and two-thirds per centum of wages during the aggregate of the periods specified for each.

(17) For the loss of a great toe, sixty-six and two-thirds per centum of wages during forty weeks.

(18) For the loss of any other toe, sixty-six and two-thirds per centum of wages during sixteen weeks.

(19) The loss of the first phalange of the great toe, or of any toe, shall be considered equivalent to the loss of one-half of such great toe, or other toe, and shall be compensated at the same rate as for the loss of a great toe, or other toe, but for one-half of the period provided for the loss of a great toe or other toe.

(20) The loss of more than one phalange of a great toe, or any toe, shall be considered equivalent to the loss of the entire great toe or other toe.

(21) For the loss of, or permanent loss of the use of any two or more such members, not constituting total disability, sixty-six and two-thirds per centum of wages during the aggregate of the periods specified for each.

(22) For serious and permanent disfigurement of the head, neck or face, of such a character as to produce an unsightly appearance, and such as is not usually incident to the employment, sixty-six and two-thirds per centum of wages not to exceed two hundred seventy-five weeks.

(23) Unless the board shall otherwise determine, the loss of both hands or both arms or both feet or both legs or both eyes shall constitute total disability, to be compensated according to the provisions of clause (a).

(24) Amputation at the wrist shall be considered as the equivalent of the loss of a hand, and amputation at the ankle shall be considered as the equivalent of the loss of a foot. Amputation between the wrist and the elbow shall be considered as the loss of a forearm, and amputation between the ankle and the knee shall be considered as the loss of a lower leg. Amputation at or above the elbow shall be considered as the loss of an arm and amputation at or above the knee shall be considered as the loss of a leg. Permanent loss of the use of a hand, arm, foot, leg, eye, finger, or thumb, great toe or other toe, shall be considered as the equivalent of the loss of such hand, arm, foot, leg, eye, finger, or thumb, great toe or other toe.

(25) In addition to the payments hereinbefore provided for permanent injuries of the classes specified, any period of disability necessary and required as a healing period shall be compensated in accordance with the provisions of this subsection. The healing period shall end (i) when the claimant returns to employment without impairment in earnings, or (ii) on the last day of the period specified in the following table, whichever is the earlier;

For the loss of a hand, twenty weeks.

For the loss of a forearm, twenty weeks.

For the loss of an arm, twenty weeks.

For the loss of a foot, twenty-five weeks.

For the loss of the lower leg, twenty-five weeks.

For the loss of a leg, twenty-five weeks.

For the loss of an eye, ten weeks.

For the loss of hearing, ten weeks.

For the loss of a thumb or any part thereof, ten weeks.

For the loss of any other finger or any part thereof, six weeks.

For the loss of a great toe or any part thereof, twelve weeks.

For the loss of any other toe or any part thereof, six weeks.

Compensation under paragraphs (1) through (24) of this clause shall not be more than the maximum compensation payable nor less than fifty per centum of the maximum compensation payable per week for total disability as provided in subsection (a) of this section, but in no event more than the Statewide average weekly wage.

Compensation for the healing period under paragraph (25) of this clause shall be computed as provided in clause (a) of this section. When an employe works during the healing period, his wages and earning power shall be as defined in this act and he shall not receive more in wages and compensation combined than his wages at the time of the injury as defined in section three hundred and nine. Where any such permanent injury or injuries shall require an amputation at any time after the end of the healing period hereinbefore provided, the employe shall be entitled to receive compensation for the second healing period, and in the case of a second injury or amputation to the same limb prior to the expiration of the first healing period a new healing period shall commence for the period hereinbefore provided, and no further compensation shall be payable for the first healing period.

(d) Where, at the time of the injury the employe receives other injuries, separate from these which result in permanent injuries enumerated in clause (c) of this section, the number of weeks for which compensation is specified for the permanent injuries shall begin at the end of the period of temporary total disability which results from the other separate injuries, but in that event the employe shall not receive compensation provided in clause (c) of this section for the specific healing period. In the event the employe suffers two or more permanent injuries of the above enumerated classes compensable under clause (c) of this section, he shall be compensated for the largest single healing period rather than the aggregate of the healing periods.

(e) No compensation shall be allowed for the first seven days after disability begins, except as provided in this clause (e) and clause (f) of this section. If the period of disability lasts fourteen days or more, the employe shall also receive compensation for the first seven days of disability.

(f.1) (1) (i) The employer shall provide payment in accordance with this section for reasonable surgical and medical services, services rendered by physicians or other health care providers, including an additional opinion when invasive surgery may be necessary, medicines and supplies, as and when needed. Provided an employer establishes a list of at least six designated health care providers, no more than four of whom may be a coordinated care organization and no fewer than three of whom shall be physicians, the employe shall be required to visit one of the physicians or other health care providers so designated and shall continue to visit the same or another designated physician or health care provider for a period of ninety (90) days from the date of the first visit: Provided, however, That the employer shall not include on the list 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. Should invasive surgery for an employe be prescribed by a physician or other health care provider so designated by the employer, the employe shall be permitted to receive an additional opinion from any health care provider of the employe's own choice. If the additional opinion differs from the opinion provided by the physician or health care provider so designated by the employer, the employe shall determine which course of treatment to follow: Provided, That the second opinion provides a specific and detailed course of treatment. If the employe chooses to follow the procedures designated in the second opinion, such procedures shall be performed by one of the physicians or other health care providers so designated by the employer for a period of ninety (90) days from the date of the visit to the physician or other health care provider of the employe's own choice. Should the employe not comply with the foregoing, the employer will be relieved from liability for the payment for the services rendered during such applicable period. It shall

be the duty of the employer to provide a clearly written notification of the employe's rights and duties under this section to the employe. The employer shall further ensure that the employe has been informed and that he understands these rights and duties. This duty shall be evidenced only by the employe's written acknowledgment of having been informed and having understood his rights and duties. Any failure of the employer to provide and evidence such notification shall relieve the employe from any notification duty owed, notwithstanding any provision of this act to the contrary, and the employer shall remain liable for all rendered treatment. Subsequent treatment may be provided by any health care provider of the employe's own choice. Any employe who, next following termination of the applicable period, is provided treatment from a nondesignated health care provider shall notify the employer within five (5) days of the first visit to said health care provider. Failure to so notify the employer will relieve the employer from liability for the payment for the services rendered prior to appropriate notice if such services are determined pursuant to paragraph (6) to have been unreasonable or unnecessary.

(ii) In addition to the above service, the employer shall provide payment for medicines and supplies, hospital treatment, services and supplies and orthopedic appliances, and prostheses in accordance with this section. Whenever an employe shall have suffered the loss of a limb, part of a limb, or an eye, the employer shall also provide for an artificial limb or eye or other prostheses of a type and kind recommended by the doctor attending such employe in connection with such injury and any replacements for an artificial limb or eye which the employe may require at any time thereafter, together with such continued medical care as may be prescribed by the doctor attending such employe in connection with such injury as well as such training as may be required in the proper use of such prostheses. The provisions of this section shall apply to injuries whether or not loss of earning power occurs. If hospital confinement is required, the employe shall be entitled to semiprivate accommodations, but, if no such facilities are available, regardless of the patient's condition, the employer, not the patient, shall be liable for the additional costs for the facilities in a private room.

(iii) Nothing in this section shall prohibit an insurer or an employer from contracting with any individual, partnership, association or corporation to provide case management and coordination of services with regard to injured employes.

(2) Any provider who treats an injured employe shall be required to file periodic reports with the employer on a form prescribed by the department which shall include, where pertinent, history, diagnosis, treatment, prognosis and physical findings. The report shall be filed within ten (10) days of commencing treatment and at least once a month thereafter as long as treatment continues. The employer shall not be liable to pay for such treatment until a report has been filed.

(3) (i) For purposes of this clause, a provider shall not require, request or accept payment for the treatment, accommodations, products or services in excess of one hundred thirteen per centum of the prevailing charge at the seventy-fifth percentile; one hundred thirteen per centum of the applicable fee schedule, the recommended fee or the inflation index charge; one hundred thirteen per centum of the DRG payment plus pass-through costs and applicable cost or day outliers; or one hundred thirteen per centum of any other Medicare reimbursement mechanism, as determined by the Medicare carrier or intermediary, whichever pertains to the specialty service involved, determined to be applicable in this Commonwealth under the Medicare program for comparable services rendered. If the commissioner determines that an allowance for a particular provider group or service under the Medicare program is not reasonable, it may adopt, by regulation, a new allowance. If the prevailing charge, fee schedule, recommended fee,

inflation index charge, DRG payment or any other reimbursement has not been calculated under the Medicare program for a particular treatment, accommodation, product or service, the amount of the payment may not exceed eighty per centum of 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.

(ii) Commencing on January 1, 1995, the maximum allowance for a health care service covered by subparagraph (i) shall be updated as of the first day of January of each year. The update, which shall be applied to all services performed after January 1 of each year, shall be equal to the percentage change in the Statewide average weekly wage. Such updates shall be cumulative.

(iii) Notwithstanding any other provision of law, it is unlawful for a provider to refer a person for laboratory, physical therapy, rehabilitation, chiropractic, radiation oncology, psychometric, home infusion therapy or diagnostic imaging, goods or services pursuant to this section if the provider has a financial interest with the person or in the entity that receives the referral. It is unlawful for a provider to 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 such entity, would be in violation of this section. No claim for payment shall be presented by an entity to any individual, third-party payer or other entity for a service furnished pursuant to a referral prohibited under this section.

(iv) The secretary shall retain the services of an independent consulting firm to perform an annual accessibility study of health care provided under this act. The study shall include information as to whether there is adequate access to quality health care and products for injured workers and a review of the information that is provided. If the secretary determines based on this study that as a result of the health care fee schedule there is not sufficient access to quality health care or products for persons suffering injuries covered by this act, the secretary may recommend to the commissioner the adoption of regulations providing for a new allowance.

(v) An allowance shall be reviewed for reasonableness whenever the commissioner determines that the use of the allowance would result in payments more than ten per centum lower than the average level of reimbursement the provider would receive from coordinated care insurers, including those entities subject to the act of December 29, 1972 (P.L. 1701, No. 364), known as the "Health Maintenance Organization Act," and those entities known as preferred provider organizations which are subject to section 630 of the Insurance Company Law of 1921 for like treatments, accommodations, products or services. In making this determination, the commissioner shall consider the extent to which allowances applicable to other providers under this section deviate from the reimbursement such providers would receive from coordinated care insurers. Any information received as a result of this subparagraph shall be confidential.

(vi) (A) The reimbursement for drugs and professional pharmaceutical services shall be limited to one hundred ten per centum of the average wholesale price (AWP) of the product, calculated on a per unit basis, as of the date of dispensing.

(B) A physician seeking reimbursement for drugs dispensed by a physician shall include the original manufacturer's National Drug Code (NDC) number, as assigned by the Food and Drug Administration, on the bills and reports required under this section.

(C) In no event may a physician seek reimbursement in excess of one hundred ten per centum of the AWP of the drugs dispensed by a physician as determined by reference to the original manufacturer's NDC number.

(D) A repackaged NDC number may not be used and will not be considered the original manufacturer's NDC number. If a physician seeking reimbursement for drugs dispensed by a physician does not include the original manufacturer's NDC number on the bills and reports required by this section, reimbursement shall be limited to one hundred ten per centum of the AWP of the least expensive clinically equivalent drug, calculated on a per unit basis.

(E) No outpatient provider, other than a pharmacy licensed in this Commonwealth or another state, may do any of the following:

(I) Seek reimbursement for a drug listed on Schedule II in section 4(2) of the act of April 14, 1972 (P.L. 233, No. 64), known as the "Controlled Substance, Drug, Device and Cosmetic Act," dispensed in excess of one initial seven-day supply, commencing upon the employe's initial treatment by a health care provider for an injury related to a specific workers' compensation claim. Should the employe require a medical procedure, including surgery, one additional fifteen-day supply can be dispensed commencing on the date of the medical procedure.

(II) Seek reimbursement for a drug listed on Schedule III in section 4(3) of the "Controlled Substance, Drug, Device and Cosmetic Act," which contains hydrocodone dispensed in excess of one initial seven-day supply, commencing upon the employe's initial treatment by a health care provider for an injury related to a specific workers' compensation claim. Should the employe require a medical procedure, including surgery, one additional fifteen-day supply can be dispensed commencing on the date of the medical procedure.

(III) Seek reimbursement for any other drug dispensed in excess of one initial thirty-day supply, commencing upon the employe's initial treatment by a health care provider under the particular workers' compensation claim.

(IV) Seek reimbursement for any drugs dispensed within any period of time in excess of the limitations under subprovision (I), (II) and (III). If one health care provider has dispensed drugs under subprovision (I), (II) or (III), no other health care provider may submit for reimbursement for drugs dispensed to that employe under the same workers' compensation claim.

(F) Reimbursement for all drugs dispensed in accordance with this subsection shall be made at the rates set forth in this section.

(G) No outpatient provider, other than a pharmacy licensed in this Commonwealth or another state, may seek reimbursement for an over-the-counter drug.

(H) The Workers' Compensation Advisory Council shall annually conduct a study of the impact of this subclause, including calculation of the savings achieved in the dispensing of pharmaceuticals.

(I) For purposes of this subclause, clinical equivalence, in reference to a drug, means the drug has chemical equivalents which, when administered in the same amounts, will provide essentially the same therapeutic effect as measured by the control of a symptom or a disease.

(vii) The applicable Medicare fee schedule shall include fees associated with all permissible procedure codes. If the Medicare fee schedule also includes a larger grouping of procedure codes and corresponding charges than are specifically reimbursed by Medicare, a provider may use these codes, and corresponding charges shall be paid by insurers or employers. If a Medicare code exists for application to a specific provider specialty, that code shall be used.

(viii) A provider shall not fragment or unbundle charges imposed for specific care except as consistent with Medicare. Changes to a provider's codes by an insurer shall be made only as consistent with Medicare and when the insurer has sufficient information to make the changes and following consultation with the provider.

(4) Nothing in this act shall prohibit the self-insured employer, employer or insurer from contracting with a coordinated care organization for reimbursement levels different from those identified above.

(5) The employer or insurer shall make payment and providers shall submit bills and records in accordance with the provisions of this section. All payments to providers for treatment provided pursuant to this act shall be made within thirty (30) days of receipt of such bills and records unless the employer or insurer disputes the reasonableness or necessity of the treatment provided pursuant to paragraph (6). The nonpayment to providers within thirty (30) days for treatment for which a bill and records have been submitted shall only apply to that particular treatment or portion thereof in dispute; payment must be made timely for any treatment or portion thereof not in dispute. A provider who has submitted the reports and bills required by this section and who disputes the amount or timeliness of the payment from the employer or insurer shall file an application for fee review with the department no more than thirty (30) days following notification of a disputed treatment or ninety (90) days following the original billing date of treatment. If the insurer disputes the reasonableness and necessity of the treatment pursuant to paragraph (6), the period for filing an application for fee review shall be tolled as long as the insurer has the right to suspend payment to the provider pursuant to the provisions of this paragraph. Within thirty (30) days of the filing of such an application, the department shall render an administrative decision.

(6) Except in those cases in which a workers' compensation judge asks for an opinion from peer review under section 420, disputes as to reasonableness or necessity of treatment by a health care provider shall be resolved in accordance with the following provisions:

(i) The reasonableness or necessity of all treatment provided by a health care provider under this act may be subject to prospective, concurrent or retrospective utilization review at the request of an employe, employer or insurer. The department shall authorize utilization review organizations to perform utilization review under this act. Utilization review of all treatment rendered by a health care provider shall be performed by a provider licensed in the same profession and having the same or similar specialty as that of the provider of the treatment under review. Organizations not authorized by the department may not engage in such utilization review.

(ii) The utilization review organization shall issue a written report of its findings and conclusions within thirty (30) days of a request.

(iii) The employer or the insurer shall pay the cost of the utilization review.

(iv) If the provider, employer, employe or insurer disagrees with the finding of the utilization review organization, a petition for review by the department must be filed within thirty (30) days after receipt of the report. The department shall assign the petition to a workers' compensation judge for a hearing or for an informal conference under section 402.1. The utilization review report shall be part of the record before the workers' compensation judge. The workers' compensation judge shall consider the utilization review report as evidence but shall not be bound by the report.

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

(8) If the employe shall refuse reasonable services of health care providers, surgical, medical and hospital services, treatment, medicines and supplies, he shall forfeit all rights to compensation for any injury or increase in his incapacity shown to have resulted from such refusal.

(9) The payment by an insurer or employer for any medical, surgical or hospital services or supplies after any statute of limitations provided for in this act shall have expired shall not act to reopen or revive the compensation rights for purposes of such limitations.

(10) If acute care is provided in an acute care facility to a patient with an immediately life threatening or urgent injury by a Level I or Level II trauma center accredited by the Pennsylvania Trauma Systems Foundation under the act of July 3, 1985 (P.L. 164, No. 45), known as the "Emergency Medical Services Act," or to a burn injury patient by a burn facility which meets all the service standards of the American Burn Association, or if basic or advanced life support services, as defined and licensed under the "Emergency Medical Services Act," are provided, the amount of payment shall be the usual and customary charge.

(f.2) (1) Medical services required by the act may be provided through a coordinated care organization which is certified by the secretary subject to the following:

(i) Each application for certification shall be accompanied by a reasonable fee prescribed by the department. A certificate is valid for such period as the department may prescribe unless sooner revoked or suspended.

(ii) Application for certification shall be made in such form and manner as the department shall require and shall set forth information regarding the proposed plan for providing services.

(iii) Where the secretary certifies that the coordinated care organization within which all of the designated physicians or other health care providers referred to in clause (f.1)(1)(i) are members, the secretary shall ensure that all the requirements of this clause are met.

(2) The coordinated care organization shall include an adequate number and specialty distribution of licensed health care providers in order to assure appropriate and timely delivery of services required under the act and an appropriate flexibility to workers in selecting providers. Services may be provided directly, through affiliates or through contractual referral arrangements with other health care providers.

(3) The secretary shall certify an entity as a coordinated care organization if the secretary finds that the entity:

(i) Possesses the capacity to provide all primary medical services as designated by the secretary in a manner that is timely and effective.

(ii) Maintains a referral capacity to treat other injuries and illnesses not covered by primary services but which are covered by this act.

(iii) Provides a case management and evaluation system which includes continuous monitoring of treatment from onset of injury or illness until final resolution.

(iv) Provides a case communication system which relates necessary and appropriate information among the employe, employer, health care providers and insurer.

(v) Provides appropriate peer and utilization review and a care dispute resolution system.

(vi) Meets quality of care and cost-effectiveness standards based upon accepted standards in the profession, including health care effectiveness measures of the Pennsylvania Health Care Cost Containment Council and recommendations on quality of care by the Workers' Compensation Advisory Council.

(vii) Complies with any other requirements of law regarding delivery of health care services.

(viii) Establishes a written grievance procedure for prompt and effective resolution of patient grievances.

(4) The secretary shall refuse to certify or may revoke or suspend certification of any coordinated care organization if the secretary finds that:

(i) the plan for providing health care services fails to meet the requirements of this section;

(ii) service under the plan is not being provided in accordance with terms of the plan as certified; or

(iii) services under the plan do not meet accepted professional standards for quality, cost-effective health care.

(5) A person participating in utilization review, quality assurance or peer review activities pursuant to this section shall not be examined as to any communication made in the course of such activities or the findings thereof, nor shall any person be subject to an action for civil damages for actions taken or statements made in good faith.

(6) Health care providers designated as rural by HCFA or located in a county with a rural Health Professional Shortage Area who are attempting to form or operate a coordinated care organization may be excluded from meeting some or all of the minimum requirements set forth in paragraphs (2) and (3), as shall be determined in rules or regulations promulgated by the department.

(7) The department shall have the power and authority to promulgate, adopt, publish and use regulations for the implementation of this section.

(g) Should the employe die from some other cause than the injury, payments of compensation to which the deceased would have been entitled to under section 306(c)(1) to (25) shall be paid to the following persons who at the time of the death of the deceased were dependents within the definition of clause (7) of section 307 and in the following order and amounts:

(1) To the surviving widow or widower if there are no children under the age of eighteen.

(2) To a surviving widow or widower and a surviving child or children in which event the widow or widower shall receive one-half and the surviving child or children shall receive the other half.

(3) To a surviving child or children if there is no surviving widow or widower.

(4) If there is no surviving widow or widower and no surviving child or children of the deceased then to that dependent or those dependents named in clause (5) of section 307.

(5) If there are no persons eligible as named above or in those classes then to those persons who are named in clause (6) of section 307.

(6) When such compensation is paid to dependents above named, compensation shall not cease even though the person receiving the payments ceases to be a dependent as defined in section 307.

(7) If there be no dependents eligible to receive payments under this section then the payment shall be made to the estate of the deceased but in an amount not exceeding reasonable funeral expenses as provided in this act or if there be no estate, to the person or persons paying the funeral expenses of such deceased in an amount not exceeding reasonable funeral expenses as provided in this act.

(h) The following schedule of compensation is hereby established:

Any person receiving compensation under Section 306(a) or (c)(23) or 307 as a result of an injury which occurred prior to August 31, 1993, shall, beginning January 1, 2007, receive a minimum amount of one hundred dollars ($100) per week. The additional compensation shall be paid by the self-insured employer or insurance carrier making payment and shall be reimbursed in advance by the Commonwealth on a quarterly basis as provided in rules and regulations of the department. The payment of additional compensation shall be made by the carrier or self-insured employer only during those fiscal years for which appropriations are made to cover reimbursement.

Sec 306.1 If an employe, who has incurred (through injury or otherwise) permanent partial disability, through the loss, or loss of use of, one hand, one arm, one foot, one leg or one eye, incurs total disability through a subsequent injury, causing loss, or loss of use of, another hand, arm, foot, leg or eye, he shall be entitled to additional compensation as follows:

After the cessation of payments by the employer for the period of weeks prescribed in clause (c) of Section 306, for the subsequent injury, additional compensation shall be paid during the continuance of total disability, at the weekly compensation rate applicable for total disability. This additional compensation shall be paid by the department out of the subsequent injury fund created pursuant to Section 306. All claims for such additional compensation shall be forever barred unless the employe shall have filed a petition therefor with the department in the same manner and within the same time as provided in Section 315 with respect to other injuries. Where, however, a person is receiving benefits pursuant to the act of June 28, 1935 (P.L. 477, No. 193), referred to as the Heart and Lung Act, the two-year period in which parties must file a petition for additional compensation, shall not begin to run until the expiration of the receipt of benefits pursuant to the Heart and Lung Act.

The department of labor and industry shall be charged with the conservation of the assets of said appropriation. In furtherance of this purpose, the attorney general shall appoint a member of his staff to represent the subsequent injury fund in all proceedings brought to enforce claims against such fund. In its award the department of labor and industry shall specifically find the amount the injured employe shall be paid weekly, the number of weeks compensation which shall be paid by the employer, the date upon which payments shall begin, and if possible the length of time such payments shall continue.

Any benefits received by any employe, or to which he may be entitled, by reason of such increased disability, from any state or federal fund or agency to which said employe has not directly contributed, shall be regarded as a credit to any award made against the Commonwealth as aforesaid, excepting those benefits received by an employe by reason of service connected physical injuries, incurred during any war between the United States of America and any foreign country.

Sec 306.2 The sum of one hundred thousand dollars ($100,000) is hereby appropriated to the Department of Labor and Industry for the Subsequent Injury Fund by the Commonwealth for the 1971-1972 fiscal year and this fund shall be maintained at one hundred thousand dollars ($100,000) by assessing each insurer a proportion of the amount expended from the fund during the preceding year, that the total compensation paid by such insurers during such year bore to the total compensation paid by all insurers that year: Provided, however, That in the first year in which assessments are made under this provision, the total amount assessed and collected shall be two hundred per centum of the amount paid in such cases during the preceding year.

Sec 307 In case of death, compensation shall be computed on the following basis, and distributed to the following persons: Provided, That in no case shall the wages of the deceased be taken to be less than fifty per centum of the Statewide average weekly wage for purposes of this section:

(1) If there be no widow nor widower entitled to compensation, compensation shall be paid to the guardian of the child or children, or, if there be no guardian, to such other persons as may be designated by the board as hereinafter provided as follows:

(a) If there be one child, thirty-two per centum of wages of deceased, but not in excess of the Statewide average weekly wage.

(b) If there be two children, forty-two per centum of wages of deceased, but not in excess of the Statewide average weekly wage.

(c) If there be three children, fifty-two per centum of wages of deceased, but not in excess of the Statewide average weekly wage.

(d) If there be four children, sixty-two per centum of wages of deceased, but not in excess of the Statewide average weekly wage.

(e) If there be five children, sixty-four per centum of wages of deceased, but not in excess of the Statewide average weekly wage.

(f) If there be six or more children, sixty-six and two-thirds per centum of wages of deceased, but not in excess of the Statewide average weekly wage.

The amounts payable under (b), (c), (d), (e) and (f) of clause (1) of this section shall be divided equally among the children if those children are with different guardians.

(2) To the widow or widower, if there be no children, fifty-one per centum of wages, but not in excess of the Statewide average weekly wage.

(3) To the widow or widower who is the guardian of all the deceased's children, payment shall be as follows:

(a) If there is one child, sixty per centum of wages, but not in excess of the Statewide average weekly wage.

(b) If there are two or more children, sixty-six and two-thirds per centum of wages, but not in excess of the Statewide average weekly wage.

(4) If there is a widow or widower who is not the guardian of all of the deceased's children, the widow or widower and to the respective guardians as follows:

(a) If there is one child, a total of sixty per centum of wages, but not in excess of the Statewide average weekly wage, to be divided equally between the widow or widower and the child.

(b) If there are two or more children, a total of sixty-six and two-thirds per centum of wages, but not in excess of the Statewide average weekly wage, to be divided as follows: thirty-three and one-third per centum to the widow or widower and the remainder to be divided equally among the children.

(5) If there be neither widow, widower, nor children entitled to compensation, then to the father or mother, if dependent to any extent upon the employe at the time of the injury, thirty-two per centum of wages but not in excess of the Statewide average weekly wage: Provided, however, That in the case of a minor child who has been contributing to his parents, the dependency of said parents shall be presumed: And provided further, That if the father or mother was totally dependent upon the deceased employe at the time of the injury, the compensation payable to such father or mother shall be fifty-two per centum of wages, but not in excess of the Statewide average weekly wage.

(6) If there be neither widow, widower, children, nor dependent parent, entitled to compensation, then to the brothers and sisters, if actually dependent upon the decedent for support at the time of his death, twenty-two per centum of wages for one brother or sister, and five per centum additional for each additional brother or sister, with a maximum of thirty-two per centum of wages of deceased, but not in excess of the Statewide average wage, such compensation to be paid to their guardian, or if there be no guardian, to such other person as may be designated by the board, as hereinafter provided.

(7) Whether or not there be dependents as aforesaid, the reasonable expense of burial, not exceeding three thousand dollars ($3,000), which shall be paid by the employer or insurer directly to the undertaker (without deduction of any amounts theretofore paid for compensation or for medical expenses).

Compensation shall be payable under this section to or on account of any child, brother, or sister, only if and while such child, brother, or sister, is under the age of eighteen unless such child, brother or sister is dependent because of disability when compensation shall continue or be paid during such disability of a child, brother or sister over eighteen years of age or unless such child is enrolled as a full-time student in any accredited educational institution when compensation shall continue until such student becomes twenty-three. No compensation shall be payable under this section to a widow, unless she was living with her deceased husband at the time of his death, or was then actually dependent upon him and receiving from him a substantial portion of her support. No compensation shall be payable under this section to a widower, unless he be incapable of self-support at the time of his wife's death and be at such time dependent upon her for support. If members of decedent's household at the time of his death, the terms "child" and "children" shall include stepchildren, adopted children and children to whom he stood in loco parentis, and children of the deceased and shall include posthumous children. Should any dependent of a deceased employe die or remarry, or should the widower become capable of self-support, the right of such dependent or widower to compensation

under this section shall cease except that if a widow remarries, she shall receive one hundred four weeks compensation at a rate computed in accordance with clause (2) in a lump sum after which compensation shall cease: Provided, however, That if, upon investigation and hearing, it shall be ascertained that the widow or widower is living with a man or woman, as the case may be, in meretricious relationship and not married, or the widow living a life of prostitution, the board may order the termination of compensation payable to such widow or widower. If the compensation payable under this section to any person shall, for any cause, cease, the compensation to the remaining persons entitled thereunder shall thereafter be the same as would have been payable to them had they been the only persons entitled to compensation at the time of the death of the deceased.

The board may, if the best interest of a child or children shall so require, at any time order and direct the compensation payable to a child or children, or to a widow or widower on account of any child or children, to be paid to the guardian of such child or children, or, if there be no guardian, to such other person as the board as hereinafter provided may direct. If there be no guardian or committee of any minor, dependent, or insane employe, or dependent, on whose account compensation is payable, the amount payable on account of such minor, dependent, or insane employe, or dependent may be paid to any surviving parent, or such other person as the board may order and direct, and the board may require any person, other than a guardian or committee, to whom it has directed compensation for a minor, dependent, or insane employe, or dependent to be paid, to render, as and when it shall so order, accounts of the receipts and disbursements of such person, and to file with it a satisfactory bond in a sum sufficient to secure the proper application of the moneys received by such person.

Sec 308 Except as hereinafter provided, all compensation payable under this article shall be payable in periodical installments, as the wages of the employe were payable before the injury.

Sec 308.1 (a) The eligibility of professional athletes for compensation under this act shall be limited as provided in this section.

(b) The term "professional athlete," as used in this section, shall mean a natural person employed as a professional athlete by a franchise of the National Football League, the National Basketball Association, the National Hockey League, the National League of Professional Baseball Clubs or the American League of Professional Baseball Clubs, under a contract for hire or a collective bargaining agreement, whose wages as defined in section 309 are more than eight times the Statewide average weekly wage.

(c) In the case of a professional athlete, any compensation payable under this act with respect to partial disability shall be reduced by the after-tax amount of any:

(1) Wages payable by the employer during the period of disability under a contract for hire or collective bargaining agreement.

(2) Payments under a self-insurance, wage continuation, disability insurance or similar plan funded by the employer.

(3) Injury protection or other injury benefits payable by the employer under a contract for hire or collective bargaining agreement.

(d) No reduction shall be made pursuant to clause (c) against any compensation payable under this act which becomes due and payable on a date after the expiration or termination of the professional athlete's employment contract, except for any amounts paid by the employer pursuant to the contract.

(e) In the case of a professional athlete, the term "wages of the injured employe" as used in section 306(b) for the purpose of computing compensation for partial disability shall mean two times the Statewide average weekly wage.

Sec 309 Wherever in this article the term "wages" is used, it shall be construed to mean the average weekly wages of the employe, ascertained as follows:

(a) If at the time of the injury the wages are fixed by the week, the amount so fixed shall be the average weekly wage;

(b) If at the time of the injury the wages are fixed by the month, the average weekly wage shall be the monthly wage so fixed multiplied by twelve and divided by fifty-two;

(c) If at the time of the injury the wages are fixed by the year, the average weekly wage shall be the yearly wage so fixed divided by fifty-two;

(d) If at the time of the injury the wages are fixed by any manner not enumerated in clause (a), (b) or (c), the average weekly wage shall be calculated by dividing by thirteen the total wages earned in the employ of the employer in each of the highest three of the last four consecutive periods of thirteen calendar weeks in the fifty-two weeks immediately preceding the injury and by averaging the total amounts earned during these three periods.

(d.1) If the employe has not been employed by the employer for at least three consecutive periods of thirteen calendar weeks in the fifty-two weeks immediately preceding the injury, the average weekly wage shall be calculated by dividing by thirteen the total wages earned in the employ of the employer for any completed period of thirteen calendar weeks immediately preceding the injury and by averaging the total amounts earned during such periods.

(d.2) If the employe has worked less than a complete period of thirteen calendar weeks and does not have fixed weekly wages, the average weekly wage shall be the hourly wage rate multiplied by the number of hours the employe was expected to work per week under the terms of employment.

(e) Except as provided in clause (d.1) or (d.2), in occupations which are exclusively seasonal and therefore cannot be carried on throughout the year, the average weekly wage shall be taken to be one-fiftieth of the total wages which the employe has earned from all occupations during the twelve calendar months immediately preceding the injury, unless it be shown that during such year, by reason of exceptional causes, such method of computation does not ascertain fairly the earnings of the employe, in which case the period for calculation shall be extended so far as to give a basis for the fair ascertainment of his average weekly earnings.

The terms "average weekly wage" and "total wages," as used in this section, shall include board and lodging received from the employer, and gratuities reported to the United States Internal Revenue Service by or for the employe for Federal income tax purposes, but such terms shall not include amounts deducted by the employer under the contract of hiring for labor furnished or paid for by the employer and necessary for the performance of such contract by the employe, nor shall such terms include deductions from wages due the employer for rent and supplies necessary for the employe's use in the performance of his labor, nor shall such terms include fringe benefits, including, but not limited to, employer payments for or contributions to a retirement, pension, health and welfare, life insurance, social security or any other plan for the benefit of the employe or his dependents: Provided, however, That the amount of any bonus, incentive or vacation payment earned on an annual basis shall be excluded from the calculations under clauses (a) through (d.2). Such payments if any shall instead be divided by fifty-two and the amount shall be added to the average weekly wage otherwise calculated under clauses (a) through (d.2).

Where the employe is working under concurrent contracts with two or more employers, his wages from all such employers shall be considered as if earned from the employer liable for compensation.

Sec 310 Alien widows, children and parents, not residents of the United States, shall be entitled to compensation, but only to the amount of fifty per centum of the compensation which would have been payable if they were residents of the United States: Provided, That compensation benefits are granted residents of the United States under the laws of the foreign country in which the widow, children or parents reside. Alien widowers, brothers and sisters who are not residents of the United States shall not be entitled to receive any compensation. In no event shall any nonresident alien widow or parent be entitled to compensation in the absence of proof that the alien widow or parent has actually been receiving a substantial portion of his or her support from the decedent. Where transmission of funds in payment of any such compensation is prohibited by any law of the Commonwealth or of the United States to residents of such foreign country, then no compensation shall accrue or be payable while such prohibition remains in effect and, unless such prohibition is removed within six years from the date of death, all obligation to pay compensation under this section shall be forever extinguished.

In every instance where an award is made to alien widows, children or parents, not residents in the United States, the referee or the board shall, in the award, fix the amount of any fee allowed to any person for services in connection with presenting the claim, and it shall be a misdemeanor punishable by a fine of not more than five hundred dollars, or imprisonment for not more than six months, or both, to accept any remuneration for the services other than that provided by the referee or board.

Sec 311 Unless the employer shall have knowledge of the occurrence of the injury, or unless the employe or someone in his behalf, or some of the dependents or someone in their behalf, shall give notice thereof to the employer within twenty-one days after the injury, no compensation shall be due until such notice be given, and, unless such notice be given within one hundred and twenty days after the occurrence of the injury, no compensation shall be allowed. However, in cases of injury resulting from ionizing radiation or any other cause in which the nature of the injury or its relationship to the employment is not known to the employe, the time for giving notice shall not begin to run until the employe knows, or by the exercise of reasonable diligence should know, of the existence of the injury and its possible relationship to his employment. The term "injury" in this section means, in cases of occupational disease, disability resulting from occupational disease.

Sec 311.1 (a) If an employe files a petition seeking compensation under section 306(a) or (b) or is receiving compensation under section 306(a) or (b), the employe shall report, in writing, to the insurer the following:

(1) If the employe has become or is employed or self-employed in any capacity.

(2) Any wages from such employment or self-employment.

(3) The name and address of the employer.

(4) The amount of wages from such employment or self-employment.

(5) The dates of such employment or self-employment.

(6) The nature and scope of such employment or self-employment.

(7) Any other information which is relevant in determining the entitlement to or amount of compensation.

(b) The report referred to in clause (a) must be made as soon as possible but no later than thirty days after such employment or self-employment occurs.

(c) An employe is obligated to cooperate with the insurer in an investigation of employment, self-employment, wages and physical condition.

(d) If an employe files a petition seeking compensation under section 306(a) or (b) or is receiving compensation under section 306(a) or (b), the insurer may submit a verification form to the employe either by mail or in person. The form shall request verification by the employe that the employe's status regarding the entitlement to receive compensation has not changed and a notation of any changes of which the employe is aware at the time the employe completes the verification, including employment, self-employment, wages and change in physical condition. Such verification shall not require any evaluation by a third party; however, it shall include a certification evidenced by the employe's signature that the statement is true and correct and that the claimant is aware of the penalties provided by law for making false statements for the purpose of obtaining compensation.

(e) The employe is obligated to complete accurately the verification form and return it to the insurer within thirty days of receipt by the employe of the form. However, the use of the verification form by the insurer and the employe's completion of such form do not relieve the employe of obligations under clauses (a), (b) and (c).

(f) The insurer may require the employe to complete the verification form at intervals of no less than six months.

(g) If the employe fails to return the completed verification form within thirty days, the insurer is permitted to suspend compensation until the completed verification form is returned. The verification form utilized by the insurer shall clearly provide notice to the employe that failure to complete the form within thirty days may result in a suspension of compensation payments.

Sec 312 The notice referred to in section 311 shall inform the employer that a certain employe received an injury, described in ordinary language, in the course of his employment on or about a specified time, at or near a place specified.

Sec 313 The notice referred to in sections 311 and 312 may be given to the immediate or other superior of the employe, to the employer, or any agent of the employer regularly employed at the place of employment of the injured employe. Knowledge of the occurrence of the injury on the part of any such agents shall be the knowledge of the employer.

Sec 314 (a) At any time after an injury the employe, if so requested by his employer, must submit himself at some reasonable time and place for a physical examination or expert interview by an appropriate health care provider or other expert, who shall be selected and paid for by the employer. If the employe shall refuse upon the request of the employer, to submit to the examination or expert interview by the health care provider or other expert selected by the employer, a workers' compensation judge assigned by the department may, upon petition of the employer, order the employe to submit to such examination or expert interview at a time and place set by the workers' compensation judge and by the health care provider or other expert selected and paid for by the employer or by a health care provider or other expert designated by the workers' compensation judge and paid for by the employer. The workers' compensation judge may at any time after such first examination or expert interview, upon petition of the employer, order the employe to submit himself to such further physical examinations or expert interviews as the workers' compensation judge shall deem reasonable and necessary, at such times and places and by such health care provider or other expert as the workers' compensation judge may designate; and in such case, the employer shall pay the fees and expenses of the examining health care provider or other expert, and the reasonable traveling expenses and loss of wages incurred by the employe in order to submit himself to such examination or expert interview. The refusal or neglect, without reasonable cause or excuse, of the employe to submit to such examination or expert interview ordered by the workers' compensation judge, either before or after an agreement or award, shall

deprive him of the right to compensation, under this article, during the continuance of such refusal or neglect, and the period of such neglect or refusal shall be deducted from the period during which compensation would otherwise be payable.

(b) In the case of a physical examination, the employe shall be entitled to have a health care provider of his own selection, to be paid by him, participate in such examination requested by his employer or ordered by the workers' compensation judge. In instances where an examination is requested in relation to section 306(a.2)(1), such examination shall be performed by a physician who is licensed in this Commonwealth, who is certified by an American Board of Medical Specialties approved board or its osteopathic equivalent and who is in active clinical practice for at least twenty (20) hours per week.

[Editor's Note: Section 315 has been reproduced twice to allow consideration of the apparent conflict created by the amendments to this section in 1974. Act 56 of 1974 added the references to the Heart and Lung Act. Subsequently, Act 263 of 1974 extended the time for filing a claim from two years to three years, but did not reference the Heart and Lung language added by Act 56. See 1 Pa.C.S.A. § 1955.]

Sec 315 In cases of personal injury all claims for compensation shall be forever barred, unless, within two years after the injury, the parties shall have agreed upon the compensation payable under this article; or unless within two years after the injury, one of the parties shall have filed a petition as provided in article four hereof. In cases of death all claims for compensation shall be forever barred, unless within two years after the death, the parties shall have agreed upon the compensation under this article; or unless, within two years after the death, one of the parties shall have filed a petition as provided in article four hereof. Where, however, in the case of any person receiving benefits pursuant to the act of June 28, 1935 (P.L. 477, No. 193), referred to as the Heart and Lung Act, the two-year period in which parties must agree upon the compensation or file a petition for compensation in cases of personal injury or in death, shall not begin to run until the expiration of the receipt of benefits pursuant to the Heart and Lung Act. Where, however, payments of compensation had been made in any case, said limitations shall not take effect until the expiration of two years from the time of making of the most recent payment prior to date of filing such petition: Provided, that any payment made under an established plan or policy of insurance for the payment of benefits on account of nonoccupational illness or injury and which payment is identified as not being workmen's compensation shall not be considered to be payment in lieu of workmen's compensation, and such payment shall not toll the running of the statute of limitations. However, in cases of injury resulting from ionizing radiation in which the nature of the injury or its relationship to the employment is not known to the employe, the time for filing a claim shall not begin to run until the employe knows, or by the exercise of reasonable diligence should know, of the existence of the injury and its possible relationship to his employment. The term "injury" in this section means, in cases of occupational disease, disability resulting from occupational disease.

[Editor's Note: Text as amended by Act No. 56 of 1974.]

Sec 315 In cases of personal injury all claims for compensation shall be forever barred, unless, within three years after the injury, the parties shall have agreed upon the compensation payable under this article; or unless within three years after the injury, one of the parties shall have filed a petition as provided in article four hereof. In cases of death all claims for compensation shall be forever barred, unless within three years after the death, the parties shall have agreed upon the compensation under this article; or unless, within three years after the death, one of the parties shall have filed a petition as provided in article four hereof. Where, however, payments of compensation have been made in any case, said limitations shall not take effect until the expiration of three years from the time of the making of the most recent payment prior to date of filing such petition: Provided, That any payment made under an established plan or policy of insurance for the payment of benefits on account of non-occupational illness or injury and which payment is identified as not being workmen's compensation shall not be considered to be payment in lieu of workmen's compensation, and such payment shall not toll the running of the Statute of Limitations. However, in cases of injury resulting from ionizing radiation in which the nature of the injury or its relationship to the employment is not known to the employe, the time for filing a claim shall not begin to run until the employe knows, or by the exercise of

reasonable diligence should know, of the existence of the injury and its possible relationship to his employment. The term "injury" in this section means, in cases of occupational disease, disability resulting from occupational disease.

[Editor's Note: Text as amended by Act No. 263 of 1974.]

Sec 316 The compensation contemplated by this article may at any time be commuted by the board, at its then value when discounted at five per centum interest, with annual rests, upon application of either party, with due notice to the other, if it appear that such commutation will be for the best interest of the employe or the dependents of the deceased employe, and that it will avoid undue expense or undue hardship to either party, or that such employe or dependent has removed or is about to remove from the United States, or that the employer has sold or otherwise disposed of the whole or the greater part of his business or assets: Provided, however, That unless the employer agrees to make such commutation, the board may require the employe or the dependents of the deceased employe to furnish proper indemnity safeguarding the employer's rights. Nothing in this section shall prohibit, restrict or impair the right of the parties to enter into a compromise and release by stipulation in accord with section 449.

Sec 317 At any time after the approval of an agreement or after the entry of the award, a sum equal to all future instalments of compensation may (where death or the nature of the injury renders the amount of future payments certain), with the approval of the board, be paid by the employer to any savings bank, trust company, or life insurance company, in good standing and authorized to do business in this Commonwealth, and such sum, together with all interest thereon, shall thereafter be held in trust for the employe or the dependents of the employe, who shall have no further recourse against the employer. The payment of such sum by the employer, evidenced by the receipt of the trustee noted upon the prothonotary's docket, shall operate as a satisfaction of said award as to the employer. Payments from said fund shall be made by the trustee in the same amounts and at the same periods as are herein required of the employer, until said fund and interest shall be exhausted. In the appointment of the trustee preference shall be given in the discretion of the board, to the choice of the employe or the dependents of the deceased employe. Should, however, there remain any unexpended balance of any fund after the payment of all sums due under this act, such balance shall be repaid to the employer who made the original payment, or to his legal representatives.

Sec 318 The right of compensation granted by this article of this act shall have the same preference (without limit of amount) against the assets of an employer, liable for such compensation, as is now or may hereafter be allowed by law for a claim for unpaid wages for labor: Provided, however, That no claim for compensation shall have priority over any judgment, mortgage, or conveyance of land recorded prior to the filing of the petition, award, or agreement as to compensation in the office of the prothonotary of the county in which the land is situated. Claims for payments due under this article of this act and compensation payments made by virtue thereof shall not be assignable.

Sec 319 Where the compensable injury is caused in whole or in part by the act or omission of a third party, the employer shall be subrogated to the right of the employe, his personal representative, his estate or his dependents, against such third party to the extent of the compensation payable under this article by the employer; reasonable attorney's fees and other proper disbursements incurred in obtaining a recovery or in effecting a compromise settlement shall be prorated between the employer and employe, his personal representative, his estate or his dependents. The employer shall pay that proportion of the attorney's fees and other proper disbursements that the amount of compensation paid or payable at the time of recovery or settlement bears to the total recovery or settlement. Any recovery against such third person in excess of the compensation theretofore paid by the employer shall be paid forthwith to the employe, his personal representative, his estate or his dependents, and shall be treated as an advance payment by the employer on account of any future instalments of compensation.

Where an employe has received payments for the disability or medical expense resulting from an injury in the course of his employment paid by the employer or an insurance company on the basis that the injury

and disability were not compensable under this act in the event of an agreement or award for that injury the employer or insurance company who made the payments shall be subrogated out of the agreement or award to the amount so paid, if the right to subrogation is agreed to by the parties or is established at the time of hearing before the referee or the board.

Sec 320 (a) If the employe at the time of the injury is a minor, under the age of eighteen years, employed or permitted to work in violation of any provision of the laws of this Commonwealth relating to minors of such age, compensation, either in the case of injury or death of such employe, shall be one hundred and fifty per centum of the amount that would be payable to such minor if legally employed. The amount by which such compensation shall exceed that provided for in case of legal employment may be referred to as "additional compensation."

(b) The employer and not the insurance carrier shall be liable for the additional compensation. Any provision in an insurance policy undertaking to relieve an employer from such liability shall be void.

(c) Where death or the nature of the injury renders the amount of future payments certain, the total amount of the additional compensation, subject to discount as in the case of commutation, shall be immediately due and payable. It shall be deposited, subject to the approval of the board, in any savings bank, trust company, or life insurance company in good standing and authorized to do business in this Commonwealth.

Where the amount of the future payments of compensation is uncertain, the board shall, upon the approval of the agreement or the entry of an award, determine as nearly as may be the total amount of payment to be made, and the additional compensation so calculated shall, immediately upon such determination, become due and payable by the employer. The amount may be redetermined by the board and any increase shall then become due and payable, and any excess, which shall be shown to have been paid, shall be returned to the person paying the same. Upon determination of the amount due, it shall be deposited as above provided. Payments of compensation out of deposits shall be made to the employe or dependents as payments of other compensation are made: Provided, however, That the board may, in its discretion and upon inquiry as in cases of commutation, accelerate such payments.

(d) The provisions of the foregoing paragraph (c) shall not apply to employers who are exempted by the department from the necessity of carrying insurance.

(e) Possession of an employment certificate, duly issued and transmitted to the employer in accordance with the provisions of the child labor law and receipt thereof duly acknowledged by him, shall be conclusive evidence to such employer of his legal right to employ the minor for whose employment such certificate has been issued.

(f) The possession of an age certificate, duly issued and transmitted to the employer by the school authorities of the school district in which a minor resides, shall be conclusive evidence to the employer of the minor's age as certified therein.

(g) If neither party has elected not to be bound by the provisions of article three of the act to which this act is an amendment, in the manner prescribed by section three hundred and two of said act, they shall be held to have agreed to be bound by the provisions of this act, and to have waived any other right or remedy at law or in equity, for the recovery of damages for injuries occurring under the circumstances herein described.

Sec 321 Nothing contained in this act shall apply to or in any way affect:

(1) Any person who at the time of injury is engaged in domestic service: Provided, however, That in cases where the employer of any such person shall have, prior to such injury, by application to the department and approved by the department, elected to come within the provisions of the act, such exemption shall not apply.

(2) Any person who is a licensed real estate salesperson or an associate real estate broker affiliated with a licensed real estate broker or a licensed insurance agent affiliated with a licensed insurance agency, under a written agreement, remunerated on a commission-only basis and who qualifies as an independent contractor for State tax purposes or for Federal tax purposes under the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 1 et seq.).

Sec 322 It shall be unlawful for any employe to receive compensation under this act if he is at the same time receiving workers' compensation under the laws of the Federal Government or any other state for the same injury. Further, it shall be unlawful for an employe receiving compensation under this act simultaneously from two or more employers or insurers during any period of total disability to receive total compensation in excess of the maximum benefit under this act. Nothing in this section shall be deemed to prohibit payment of workers' compensation on a pro-rata basis, where an employe suffers from more than one injury while in the employ of more than one employer: Provided, however, That the total compensation paid shall not exceed the maximum weekly compensation payable under this act: And, Provided further, That any such pro rata calculation shall be based upon the earnings by such an employe in the employ of each such employer and that all wage losses suffered as a result of any injury which is compensable under this act shall be used as the basis for calculating the total compensation to be paid on a pro rata basis.

Sec 323 (a) A construction design professional who is retained to perform professional services on a construction project or any employe of a construction design professional who is assisting or representing the construction design professional in the performance of professional services on the site of the construction project shall not be liable under this act for any injury or death of a worker not an employe of such design professional on the construction project for which workers' compensation is payable under the provisions of this act.

(b) Notwithstanding any provisions to the contrary, this section shall apply to claims for compensation based on injuries or death which occurred after the effective date of this section.

ARTICLE IV
Procedure

Sec 401 The term "referee," when used in this act, shall mean a Workers' Compensation Judge of the Department of Labor and Industry, appointed by and subject to the general supervision of the Secretary of Labor and Industry for the purpose of conducting departmental hearings under this act. The secretary may establish different classes of these judges. Any reference in any statute to a workmen's compensation referee shall be deemed to be a reference to a workers' compensation judge.

The term "board," when used in this article, shall mean the Workers' Compensation Appeal Board, a departmental administrative board as provided in sections 202, 207, 503 and 2208 of the act of April 9, 1929 (P.L. 177), known as "The Administrative Code of 1929," exercising its powers and performing its duties as an appellate board independently of the Secretary of Labor and Industry and any other official of the department.

The term "fund," when used in this article, shall mean the State Workmen's Insurance Fund of this Commonwealth, the State-operated insurance carrier from which workmen's compensation insurance policies may be purchased by employers to cover all risks of liability under this act including those declined by private carriers.

The terms "insurer" and "carrier," when used in this article, shall mean the State Workmen's Insurance Fund or other insurance carrier which has insured the employer's liability under this act, or the employer in cases of self-insurance.

The term "employer," when used in this article, shall mean the employer as defined in article one of this act, or his duly authorized agent, or his insurer if such insurer has assumed the employer's liability or the fund if the employer be insured therein.

The term "resolution hearing," when used in this article, shall mean a procedure established by the Office of Adjudication with the sole purpose of providing a venue to present a compromise and release to a workers' compensation judge in an expedited fashion.

The term "mediation," when used in this article, shall mean a conference conducted by a workers' compensation judge, but not necessarily the judge assigned to the actual case involving the parties, and shall require the attendance in person or by teleconference of all parties, including the claimant and employer, and their respective counsel, if any. All parties shall have requisite authority to accept, modify or reject settlement proposals offered at a mediation, either at the mediation or within a reasonable time period after the mediation as established by the workers' compensation judge.

Sec 401.1 The department shall, in fulfillment of its responsibilities under this act, enforce the time standards and other performance standards herein provided for the prompt processing of injury cases and payment of compensation when due by employers and insurers both upon petition by a party or on its own motion. In any case in which compensation has not been timely paid, or in which notice of denial of compensation has been given, the department shall hear and determine all claim petitions for compensation filed by employes or their dependents. The department shall also hear and determine all petitions by employers or insurers to suspend, terminate, reduce or otherwise modify compensation payments, awards, or agreements and petitions by employes or their dependents to increase, modify or reinstate compensation payments, awards, or agreements. Hearings shall be scheduled forthwith upon receipt of the claim petition or other petition, as the case may be, and determinations thereon shall be made promptly and in conformity with time standards herein or hereunder established. Such hearings shall be conducted by a workers' compensation judge or other hearing officer designated by the secretary.

Each workers' compensation judge assigned to conduct hearings shall set forth a mandatory trial schedule at the first hearing. This trial schedule shall include specific deadlines for the presentation of evidence by the parties and dates for future hearings. Judges shall strictly enforce their schedules, and no party will be excused from honoring the schedule absent good cause shown. Every trial schedule shall include a specific date and time for a mediation conference. Mediations shall take place no later than thirty (30) days prior to the date set for filing proposed findings of fact and conclusions of law or legal briefs or memoranda unless, upon good cause shown, the workers' compensation judge determines mediation would be futile. Within one hundred twenty (120) days of the effective date of this paragraph, the Office of Adjudication shall create a resolution hearing procedure to hear compromise and release agreements in an expedited manner. The hearing shall be held within fourteen (14) business days of notice of a commutation or compromise and release.

The workers' compensation judge conducting a resolution hearing will not be required to have received formal assignment by the Workers' Compensation Bureau of the compromise and release petition prior to conducting the resolution hearing. At the time of hearing, the parties shall submit proof of filing a petition to the workers' compensation judge hearing the compromise and release matter. A workers' compensation judge shall render a decision within five (5) business days of the hearing.

Delays in hearings will be granted according to rules established by the department, and any party who unreasonably delays a hearing will be subject to a penalty as provided in section 435. Subject to the provisions of the act of July 31, 1968 (P.L. 769, No. 240), known as the "Commonwealth Documents Law," the department shall adopt such rules and regulations as it finds necessary or desirable for the enforcement of this act.

Sec 401.2 (a) The Workers' Compensation Appeal Board shall consist of at least three, and not more than fifteen, members appointed by the Governor, of whom the Governor shall designate one as chairman. An en banc board shall consist of all the appointed members on the board, a majority of which shall constitute a quorum, and no action of the board shall be valid unless it shall have the concurrence of such number of members and that number constitutes a majority of the votes cast. Where there are more than three appointed members, the board may sit in panels of three, all three members shall constitute a quorum and no action taken by a panel shall be valid unless it shall have the concurrence of a majority of the panel members. When a majority of any such panel has reached a decision, the chair of the panel shall assign the writing of an opinion and order to a panel member. The panel member shall prepare a draft opinion and award and transmit it to the secretary of the board for circulation and review to all members of the Workers' Compensation Appeal Board. Each member of the Workers' Compensation Appeal Board shall be entitled to a period of thirty (30) days from the date a draft opinion on behalf of a majority of a panel is placed in circulation by the secretary of the board in which to concur in, comment on, object to or dissent from the proposed draft opinion and award. Concurrences, comments, objections and dissents shall be transmitted to the chairman of the board, the secretary of the board and the board member responsible for writing the draft opinion. A board member who does not submit a written response to a proposed draft opinion and order circulated shall be deemed to concur in the opinion and order as drafted and initially placed in circulation in conformity with the procedure set forth in subsection (a). If, at the conclusion of the thirty-day period, a majority of the members of the board have failed to concur in the draft opinion and order as circulated, the Chairman of the Workers' Compensation Appeal Board, in consultation with the chair of the panel that heard the case in question, shall reassign the opinion to a board member for the purpose of redrafting and circulating a draft opinion and order in conformity with the procedures articulated in this subsection. A vacancy on the board shall not impair the right of a quorum to exercise all the rights and perform all the duties of the board. The Secretary of Labor and Industry, with the approval of the Governor, shall appoint a secretary to the Workers' Compensation Appeal Board, who shall receive such salary as the Secretary of Labor and Industry, with the approval of the Governor, shall determine.

(b) Members of the board shall be required to annually attend and participate in a minimum of eight (8) hours of workers' compensation-related education approved by the Pennsylvania Supreme Court Continuing Legal Education Board or a similar reputable agency approved by the department.

(c) A member of the Workers' Compensation Appeal Board shall conform to the following code of ethics:

(1) Avoid impropriety and the appearance of impropriety in all activities.

(2) Perform duties impartially and diligently.

(3) Avoid ex parte communications in any contested, on-the-record matter pending before the department.

(4) Abstain from expressing publicly, except in administrative disposition or adjudication, personal views on the merits of an adjudication pending before the department and require similar abstention on the part of department personnel subject to the member's direction and control.

(5) Require staff and personnel subject to the member's direction and control to observe the standards of fidelity and diligence that apply to a member.

(6) Refer to the Secretary of Labor and Industry disciplinary measures against department personnel subject to the member's direction and control for unethical conduct.

(7) Disqualify himself from proceedings in which impartiality may be reasonably questioned.

(8) Keep informed about the personal and fiduciary interests of himself and his immediate family.

(9) Regulate outside activities to minimize the risk of conflict with official duties. A member may speak, write or lecture, and reimbursed expenses, honoraria, royalties or other money received in connection therewith shall be disclosed annually. A disclosure statement shall be filed with the Secretary of Labor and Industry and the State Ethics Commission and shall be open to inspection by the public during the normal business hours of the department and the commission during the tenure of the member.

(10) Refrain from direct or indirect solicitation of funds for political, educational, religious, charitable, fraternal or civic purposes: Provided, however, That a member may be an officer, a director or a trustee of such organizations.

(11) Refrain from financial or business dealings which would tend to reflect adversely on impartiality. A member may hold and manage investments which are not incompatible with the duties of office.

(12) Uphold the integrity and independence of the workers' compensation system.

(d) The secretary shall ensure that there are at least two opinion writers assigned to each member of the board. Opinion writers employed by or on behalf of the board whose duties involve, in whole or in part, the writing or drafting of proposed opinions, decisions or orders for the board or any member of the board shall be required to annually attend and participate in a minimum of eight (8) hours of continuing legal education in the field of workers' compensation practice and procedure in courses approved by the Pennsylvania Supreme Court Continuing Legal Education Board.

Sec 402 All proceedings before any workers' compensation judge, except those for which an informal conference has been applied for as provided by section 402.1, shall be instituted by claim petition or other petition as the case may be or on the department's own motion, and all appeals to the board, shall be instituted by appeal addressed to the board. All claim petitions, requests for informal conferences and other petitions and appeals shall be in writing and in the form prescribed by the department.

Sec 402.1 (a) In any action for which a petition has been filed under this act, the parties by joint agreement may file a notice of request with the department for an informal conference pursuant to this act. The department shall assign the matter to a workers' compensation judge or hearing officer for an informal conference. Unless the parties jointly agree to a time extension, all proceedings within an informal conference shall be completed within thirty-five days of the filing of the request for informal conference. Joint agreement to a time extension shall stay the adjudication proceedings for the time agreed upon.

(b) At any informal conference held pursuant to this section:

(i) the workers' compensation judge or hearing officer may accept the statements of both parties, together with any medical reports, witnesses' statements or other documents which the parties would like to present;

(ii) all communications, verbal or written, from the parties to the workers' compensation judge or hearing officer and any information and evidence presented to the workers' compensation judge or hearing officer during the informal conference proceedings are confidential and shall not be a part of the record of testimony; and

(iii) each party may be represented, but the employer may only be represented by an attorney at the informal conference if the employe is also represented by an attorney at the informal conference.

(c) The workers' compensation judge or hearing officer shall attempt to resolve the issues in dispute between the parties, but in no event shall any recommendations or findings made by the workers' compensation judge or hearing officer be binding upon the parties unless accepted in writing by both parties. If the parties come to agreement, the workers' compensation judge or hearing officer shall reduce such agreement to writing, which shall be signed by all parties and filed with the department.

(d) In the event that the parties cannot resolve their dispute, the petition will be reassigned to a different workers' compensation judge for adjudication of the dispute, or, by joint agreement of the parties, the workers' compensation judge who was originally assigned the matter will proceed with the adjudication of the petition.

(e) The information provided at the informal conference does not constitute established evidence for any subsequent proceeding on the petition.

(f) No workers' compensation judge or hearing officer who participates in an informal conference conducted pursuant to this section shall be compelled or permitted to testify about any matter discussed or revealed during such proceedings in any other proceeding pursuant to this act, except matters involving fraud.

Sec 403 All petitions, all copies of notices of compensation payable and agreements for compensation, and all papers requiring action by the department and its referees or the board, shall be mailed or delivered to the department at its principal office.

Sec 404 The department shall, immediately upon their receipt, properly file and docket all claim petitions and other petitions, notices of compensation payable, agreements for compensation, findings of fact, awards or disallowances of compensation, or modifications thereof, and all other decisions, reports or papers filed with it under the provisions of this act or the rules and regulations of the department or the board.

Sec 405 Immediately upon making or receiving any award or disallowance of compensation, or any modification thereof, or any other decision, the department shall serve a copy thereof on all parties in interest.

Sec 406 All notices and copies to which any parties shall be entitled under the provisions of this article shall be served by mail, or in such manner as the department shall direct. For the purposes of this article any notice or copy shall be deemed served on the date when mailed, properly stamped and addressed, and shall be presumed to have reached the party to be served; but any party may show by competent evidence that any notice or copy was not received, or that there was an unusual or unreasonable delay in its transmission through the mails. In any such case proper allowance shall be made for the party's failure within the prescribed time to assert any right given him by this act.

The department, the secretary of the board, and every referee shall keep a careful record of the date of mailing every notice and copy required by this act to be served on the parties in interest.

Sec 406.1 (a) The employer and insurer shall promptly investigate each injury reported or known to the employer and shall proceed promptly to commence the payment of compensation due either pursuant to an agreement upon the compensation payable or a notice of compensation payable as provided in section 407 or pursuant to a notice of temporary compensation payable as set forth in subsection (d), on forms prescribed by the department and furnished by the insurer. The first installment of compensation shall be paid not later than the twenty-first day after the employer has notice or knowledge of the employe's disability. Interest shall accrue on all due and unpaid compensation at the rate of ten per centum per annum. Any payment of compensation prior or subsequent to an agreement or notice of compensation payable or a notice of temporary compensation payable or greater in amount than provided therein shall, to the extent of the amount of such payment or payments, discharge the liability of the employer with respect to such case.

(b) Payments of compensation pursuant to an agreement or notice of compensation payable may be suspended, terminated, reduced or otherwise modified by petition and subject to right of hearing as provided in section 413.

(c) If the insurer controverts the right to compensation it shall promptly notify the employe or his dependent, on a form prescribed by the department, stating the grounds upon which the right to compensation is controverted and shall forthwith furnish a copy or copies to the department.

(d) (1) In any instance where an employer is uncertain whether a claim is compensable under this act or is uncertain of the extent of its liability under this act, the employer may initiate compensation payments without prejudice and without admitting liability pursuant to a notice of temporary compensation payable as prescribed by the department.

(2) The notice of temporary compensation payable shall be sent to the claimant and a copy filed with the department and shall notify the claimant that the payment of temporary compensation is not an admission of liability of the employer with respect to the injury which is the subject of the notice of temporary compensation payable. The department shall, upon receipt of a notice of temporary compensation payable, send a notice to the claimant informing the claimant that:

(i) the payment of temporary compensation and the claimant's acceptance of that compensation does not mean the claimant's employer is accepting responsibility for the injury or that a compensation claim has been filed or commenced;

(ii) the payment of temporary compensation entitles the claimant to a maximum of ninety (90) days of compensation; and

(iii) the claimant may need to file a claim petition in a timely fashion under section 315, enter into an agreement with his employer or receive a notice of compensation payable from his employer to ensure continuation of compensation payments.

(3) Payments of temporary compensation shall commence and the notice of temporary compensation payable shall be sent within the time set forth in clause (a).

(4) Payments of temporary compensation may continue until such time as the employer decides to controvert the claim.

(5) (i) If the employer ceases making payments pursuant to a notice of temporary compensation payable, a notice in the form prescribed by the department shall be sent to the claimant and a copy filed with the department, but in no event shall this notice be sent or filed later than five (5) days after the last payment.

(ii) This notice shall advise the claimant, that if the employer is ceasing payment of temporary compensation, that the payment of temporary compensation was not an admission of liability of the employer with respect to the injury subject to the notice of temporary compensation payable, and the employe must file a claim to establish the liability of the employer.

(iii) If the employer ceases making payments pursuant to a notice of temporary compensation payable, after complying with this clause, the employer and employe retain all the rights, defenses and obligations with regard to the claim subject to the notice of temporary compensation payable, and the payment of temporary compensation may not be used to support a claim for compensation.

(iv) Payment of temporary compensation shall be considered compensation for purposes of tolling the statute of limitations under section 315.

(6) If the employer does not file a notice under paragraph (5) within the ninety-day period during which temporary compensation is paid or payable, the employer shall be deemed to have admitted liability and the notice of temporary compensation payable shall be converted to a notice of compensation payable.

Sec 407 On or after the seventh day after any injury shall have occurred, the employer or insurer and employe or his dependents may agree upon the compensation payable to the employe or his dependents under this act; but any agreement made prior to the seventh day after the injury shall have occurred, or permitting a commutation of payments contrary to the provisions of this act, or varying the amount to be paid or the period during which compensation shall be payable as provided in this act, shall be wholly null and void. It shall be unlawful for any employer to accept a receipt showing the payment of compensation when in fact no such payment has been made.

Where payment of compensation is commenced without an agreement, the employer or insurer shall simultaneously give notice of compensation payable to the employe or his dependent, on a form prescribed by the department, identifying such payments as compensation under this act and shall forthwith furnish a

copy or copies to the department as required by rules and regulations. It shall be the duty of the department to examine the notice to determine whether it conforms to the provisions of this act and rules and regulations hereunder.

All agreements made in accordance with the provisions of this section shall be on a form prescribed by the department, signed by all parties in interest, and a copy or copies thereof forwarded to the department as required by rules and regulations. It shall be the duty of the department to examine the agreement to determine whether it conforms to the provisions of this act and rules and regulations hereunder.

All notices of compensation payable and agreements for compensation and all supplemental agreements for the modification, suspension, reinstatement, or termination thereof, and all receipts executed by any injured employe of whatever age, or by any dependent to whom compensation is payable under section three hundred and seven, and who has attained the age of sixteen years, shall be valid and binding unless modified or set aside as hereinafter provided.

Sec 408 All notices of compensation payable and agreements for compensation may be modified, suspended, reinstated, or terminated at any time by an agreement or supplemental agreement as the case may be with notice to the department, if the incapacity of an injured employe has increased, decreased, recurred, or temporarily or finally terminated, or if the status of any dependent has changed.

Sec 409 Whenever an agreement or supplemental agreement shall be executed between an employer or his insurer and an employe or his dependents as provided by this act, such agreement shall be executed in triplicate. It shall be the duty of the department to examine the agreement to determine whether it conforms to the provisions of this act and rules and regulations hereunder. The employer or the insurer as the case may be shall immediately furnish one copy of the agreement to the employe or his dependents and forward another copy or copies to the department as required by rules and regulations. If compensation payments have not already been made, compensation shall be commenced forthwith upon execution of the agreement.

Sec 410 If, after any injury, the employer or his insurer and the employe or his dependent, concerned in any injury, shall fail to agree upon the facts thereof or the compensation due under this act, the employe or his dependents may present a claim petition for compensation to the department.

In case any claimant shall die before the final adjudication of his claim, the amount of compensation due such claimant to the date of death shall be paid to the dependents entitled to compensation, or, if there be no dependents, then to the estate of the decedent.

Whenever any claim for compensation is presented and the only issue involved is the liability as between the defendant or the carrier or two or more defendants or carriers, the referee of the department to whom the claim in such case is presented shall forthwith order payments to be immediately made by the defendants or the carriers in said case. After the department's referee or the board on appeal, render a final decision, the payments made by the defendant or carrier not liable in the case shall be awarded or assessed against the defendant or carrier liable in the case, as costs in the proceedings, in favor of the defendant or carrier not liable in the case.

Sec 411 Whenever the employer or his insurer and the employe or his dependent shall, on or after the seventh day after any injury, agree on all of the facts on which a claim for compensation depends, but shall fail to agree on the compensation payable, they may petition the department to determine the compensation payable. Such petition shall contain the agreed facts, and shall be signed by all parties in interest. The department or its referee shall fix a time and place for hearing the petition, and shall notify all parties in interest. As soon as may be after such hearing, the department or its referee shall award or disallow compensation in accordance with the provisions of this act.

Sec 412 If any party shall desire the commutation of future installments of compensation, he shall present a petition therefor to the department to be heard and determined by a workers' compensation judge: Provided, That where there are no more than fifty-two weeks of compensation to be commuted, the insurer or self-insurer may commute such future installments without discount upon furnishing the employe written notice of the commutation on a form prescribed by the department, a copy of which shall be filed immediately with the department. Nothing in this section shall prohibit, restrict or impair the right of the parties to enter into a compromise and release by stipulation in accord with section 449.

Sec 413 (a) A workers' compensation judge of the department may, at any time, review and modify or set aside a notice of compensation payable and an original or supplemental agreement or upon petition filed by either party with the department, or in the course of the proceedings under any petition pending before such workers' compensation judge, if it be proved that such notice of compensation payable or agreement was in any material respect incorrect.

A workers' compensation judge designated by the department may, at any time, modify, reinstate, suspend, or terminate a notice of compensation payable, an original or supplemental agreement or an award of the department or its workers' compensation judge, upon petition filed by either party with the department, upon proof that the disability of an injured employe has increased, decreased, recurred, or has temporarily or finally ceased, or that the status of any dependent has changed. Such modification, reinstatement, suspension, or termination shall be made as of the date upon which it is shown that the disability of the injured employe has increased, decreased, recurred, or has temporarily or finally ceased, or upon which it is shown that the status of any dependent has changed: Provided, That, except in the case of eye injuries, no notice of compensation payable, agreement or award shall be reviewed, or modified, or reinstated, unless a petition is filed with the department within three years after the date of the most recent payment of compensation made prior to the filing of such petition. Where, however, a person is receiving benefits pursuant to the act of June 28, 1935 (P.L. 477, No. 193), referred to as the Heart and Lung Act, the two-year period in which a petition to review, modify, or reinstate a notice of compensation, agreement or award must be filed, shall not begin to run until the expiration of the receipt of benefits pursuant to the Heart and Lung Act: And provided further, That any payment made under an established plan or policy of insurance for the payment of benefits on account of nonoccupational illness or injury and which payment is identified as not being workmen's compensation shall not be considered to be payment in lieu of workmen's compensation, and such payment shall not toll the running of the Statute of Limitations: And provided further, That where compensation has been suspended because the employe's earnings are equal to or in excess of his wages prior to the injury that payments under the agreement or award may be resumed at any time during the period for which compensation for partial disability is payable, unless it be shown that the loss in earnings does not result from the disability due to the injury.

The workers' compensation judge to whom any such petition has been assigned may subpoena witnesses, hear evidence, make findings of fact, and award or disallow compensation, in the same manner and with the same effect and subject to the same right of appeal, as if such petition were an original claim petition.

(a.1) The filing of a petition to terminate, suspend or modify a notice of compensation payable or a compensation agreement or award as provided in this section shall automatically operate as a request for a supersedeas to suspend the payment of compensation fixed in the agreement or the award where the petition alleges that the employe has fully recovered and is accompanied by an affidavit of a physician on a form prescribed by the department to that effect, which is based upon an examination made within twenty-one days of the filing of the petition. A special supersedeas hearing before a workers' compensation judge shall be held within twenty-one days of the assignment of such petition. All parties to the special supersedeas hearing shall have the right to submit, and the workers' compensation judge may consider testimony of any party or witness; the record of any physician; the records of any physician, hospital, clinic or similar entity; the written statements or reports of any other

person expected to be called by any party at the hearing of the case; and any other relevant materials. The workers' compensation judge shall rule on the request for supersedeas within seven days of the hearing and shall approve the request if prima facia evidence of a change in the medical status or of any other fact which would serve to modify or terminate payment of compensation is submitted at the hearing, unless the employe establishes, by a preponderance of the evidence, a likelihood of prevailing on the merits of his defense. The workers' compensation judge's decision on supersedeas shall be interlocutory and shall not be appealable. The determination of full recovery with respect to either the petition to terminate or modify or the request for supersedeas shall be made without consideration of whether a specific job vacancy exists for the employe for work which the employe is capable of performing or whether the employe would be hired if the employe applied for work which the employe is capable of performing.

(a.2) In any other case, a petition to terminate, suspend or modify a compensation agreement or other payment arrangement or award as provided in this section shall not automatically operate as a supersedeas but may be designated as a request for a supersedeas, which may then be granted at the discretion of the workers' compensation judge hearing the case. A supersedeas shall serve to suspend the payment of compensation in whole or to such extent as the facts alleged in the petition would, if proved, require. The workers' compensation judge hearing the case shall rule on the request for a supersedeas as soon as possible and may approve the request if proof of a change in medical status, or proof of any other fact which would serve to modify or terminate payment of compensation is submitted with the petition. The workers' compensation judge hearing the case may consider any other fact which he deems to be relevant when making the decision on the supersedeas request and the decision shall not be appealable.

(b) Any insurer who suspends, terminates or decreases payments of compensation without submitting an agreement or supplemental agreement therefor as provided in section 408, or a final receipt as provided in section 434, or without filing a petition and either alleging that the employe has returned to work at his prior or increased earnings or where the petition alleges that the employe has fully recovered and is accompanied by an affidavit of a physician on a form prescribed by the department to that effect which is based upon an examination made within twenty-one days of the filing of the petition or having requested and been granted a supersedeas as provided in this section, shall be subject to penalty as provided in section 435.

(c) Notwithstanding any provision of this act, an insurer may suspend the compensation during the time the employe has returned to work at his prior or increased earnings upon written notification of suspension by the insurer to the employe and the department, on a form prescribed by the department for this purpose. The notification of suspension shall include an affidavit by the insurer that compensation has been suspended because the employe has returned to work at prior or increased earnings. The insurer must mail the notification of suspension to the employe and the department within seven days of the insurer suspending compensation.

(1) If the employe contests the averments of the insurer's affidavit, a special supersedeas hearing before a workers' compensation judge may be requested by the employe indicating by a checkoff on the notification form that the suspension of benefits is being challenged and filing the notification of challenge with the department within twenty days of receipt of the notification of suspension from the insurer. The special supersedeas hearing shall be held within twenty-one days of the employe's filing of the notification of challenge.

(2) If the employe does not challenge the insurer's notification of suspension within twenty days under paragraph (1), the employe shall be deemed to have admitted to the return to work and receipt of wages at prior or increased earnings. The insurer's notification of suspension shall be deemed to have the same binding effect as a fully executed supplemental agreement for the suspension of benefits.

(d) Notwithstanding any provision of this act, an insurer may modify the compensation payments made during the time the employe has returned to work at earnings less than the employe earned at the time of the work-related injury, upon written notification of modification by the insurer to the employe and the department, on a form prescribed by the department for this purpose. The notification of modification shall include an affidavit by the insurer that compensation has been modified because the employe has returned to work at lesser earnings. The insurer must mail the notification of modification to the employe and the department within seven days of the insurer's modifying compensation.

(1) If the employe contests the averments of the insurer's affidavit, a special supersedeas hearing before a workers' compensation judge may be requested by the employe indicating by a checkoff on the notification form that the modification of benefits is being challenged and filing the notification of challenge with the department within twenty days of receipt of the notification of modification from the insurer. The special supersedeas hearing shall be held within twenty-one days of the employe's filing of the notification of challenge.

(2) If the employe does not challenge the insurer's notification of modification within twenty days under paragraph (1), the employe shall be deemed to have admitted to the return to work and receipt of wages at lesser earnings as alleged by the insurer. The insurer's notification of modification shall be deemed to have the same binding effect as a fully executed supplemental agreement for the modification of benefits.

Sec 414 Whenever a claim petition or other petition is presented to the department, the department shall, by general rules or special order, assign it to a workers' compensation judge for hearing. When assigning petitions, including those for resolution hearings, the department shall not assign to a particular workers' compensation judge more than seventy-five per centum of the petitions from a particular county.

The department shall serve upon each adverse party a copy of the petition, together with a notice that such petition will be heard by the workers' compensation judge to whom it has been assigned (giving his name and address) as the case may be, and shall mail the original petition to such workers' compensation judge, together with copies of the notices served upon the adverse parties.

Sec 415 At any time before an award or disallowance of compensation or order has been made by a referee to whom a petition has been assigned, the department may order such petition heard before any other referee. Unless the department shall otherwise order, the testimony taken before the original referee shall be considered as though taken before the substituted referee.

Sec 416 Within twenty days after a copy of any claim petition or other petition has been served upon an adverse party, he may file with the department or its workers' compensation judge an answer in the form prescribed by the department.

Every fact alleged in a claim petition not specifically denied by an answer so filed by an adverse party shall be deemed to be admitted by him. But the failure of any party or of all of them to deny a fact alleged in any other petition shall not preclude the workers' compensation judge before whom the petition is heard from requiring, of his own motion, proof of such fact. If a party fails to file an answer and/or fails to appear in person or by counsel at the hearing without adequate excuse, the workers' compensation judge hearing the petition shall decide the matter on the basis of the petition and evidence presented.

Sec 417 Within fifteen days after notice that a petition has been directed to be heard by a referee has been served upon the adverse parties thereof, the referee shall fix a time and place for hearing the petition. The referee shall as soon as practicable within the limitations prescribed herein fix a time and a place for hearing the petition and serve upon all parties in interest a notice of the time and place of hearing, and shall serve upon the petitioner a

copy of any answer of any adverse party. The hearing on any such petition shall be held within thirty-five days of the filing of the petition.

Sec 418 The referee to whom a petition is assigned for hearing, may subpoena witnesses, order the production of books and other writings, and hear evidence, shall make a record of hearings, and shall make, in writing and as soon as may be after the conclusion of the hearing, such findings of fact, conclusions of law, and award or disallowance of compensation or other order, as the petition and answers and the evidence produced before him and the provisions of this act shall, in his judgment, require. The findings of fact made by a referee to whom a petition has been assigned or any question of fact has been referred under the provisions of section four hundred and nineteen shall be final, unless an appeal is taken as provided in this act.

Sec 419 The board may remand any case involving any question of fact arising under any appeal to a referee to hear evidence and report to the board the testimony taken before him or such testimony and findings of fact thereon as the board may order. The department may refer any question of fact arising out of any petition assigned to a referee, to any other referee to hear evidence, and report the testimony so taken thereon to the original referee.

Sec 420 (a) The board, the department or a workers' compensation judge, if it or he deem it necessary, may, of its or his own motion, either before, during, or after any hearing, make or cause to be made an investigation of the facts set forth in the petition or answer or facts pertinent in any injury under this act. The board, department or workers' compensation judge may appoint one or more impartial physicians or surgeons to examine the injuries of the plaintiff and report thereon, or may employ the services of such other experts as shall appear necessary to ascertain the facts. The workers' compensation judge when necessary or appropriate or upon request of a party in order to rule on requests for review filed under section 306(f.1), or under other provisions of this act, may ask for an opinion from peer review about the necessity or frequency of treatment under section 306(f.1). The peer review report or the peer report of any physician, surgeon, or expert appointed by the department or by a workers' compensation judge, including the report of a peer review organization, shall be filed with the board or workers' compensation judge, as the case may be, and shall be a part of the record and open to inspection as such. The workers' compensation judge shall consider the report as evidence but shall not be bound by such report.

(b) The board or workers' compensation judge, as the case may be, shall fix the compensation of such physicians, surgeons, and experts, and other peer review organizations which, when so fixed, shall be paid out of the Workmen's Compensation Administration Fund.

Sec 421 All hearings before the board, or one or more members thereof, or before a referee shall be public.

Sec 422 (a) Neither the board nor any of its members nor any workers' compensation judge shall be bound by the common law or statutory rules of evidence in conducting any hearing or investigation, but all findings of fact shall be based upon sufficient competent evidence to justify same. All parties to an adjudicatory proceeding are entitled to a reasoned decision containing findings of fact and conclusions of law based upon the evidence as a whole which clearly and concisely states and explains the rationale for the decisions so that all can determine why and how a particular result was reached. The workers' compensation judge shall specify the evidence upon which the workers' compensation judge relies and state the reasons for accepting it in conformity with this section. When faced with conflicting evidence, the workers' compensation judge must adequately explain the reasons for rejecting or discrediting competent evidence. Uncontroverted evidence may not be rejected for no reason or for an irrational reason; the workers' compensation judge must identify that evidence and explain adequately the reasons for its rejection. The adjudication shall provide the basis for meaningful appellate review.

(b) If any party or witness resides outside of the Commonwealth, or through illness or other cause is unable to testify before the board or a workers' compensation judge, his or her testimony or

deposition may be taken, within or without this Commonwealth, in such manner and in such form as the department may, by special order or general rule, prescribe. The records kept by a hospital of the medical or surgical treatment given to an employe in such hospital shall be admissible as evidence of the medical and surgical maters stated therein.

(c) Where any claim for compensation at issue before a workers' compensation judge involves fifty-two weeks or less of disability, either the employe or the employer may submit a certificate by any health care provider as to the history, examination, treatment, diagnosis, cause of the condition and extent of disability, if any, and sworn reports by other witnesses as to any other facts and such statements shall be admissible as evidence of medical and surgical or other matters therein stated and findings of fact may be based upon such certificates or such reports. Where any claim for compensation at issue before a workers' compensation judge exceeds fifty-two weeks of disability, a medical report shall be admissible as evidence unless the party that the report is offered against objects to its admission.

(d) Where an employer shall have furnished surgical and medical services or hospitalization in accordance with the provisions of section 306(f.1), or where the employe has himself procured them, the employer or employe shall, upon request, in any pending proceeding, be furnished with, or have made available, a true and complete record of the medical and surgical services and hospital treatment, including X rays, laboratory tests, and all other medical and surgical data in the possession or under the control of the party requested to furnish or make available such data.

(e) The department may adopt rules and regulations governing the conduct of all hearings held pursuant to any provisions of this act, and hearings shall be conducted in accordance therewith, and in such manner as best to ascertain the substantial rights of the parties.

Sec 423 (a) Any party in interest may, within twenty days after notice of a workers' compensation judge's adjudication shall have been served upon him, take an appeal to the board on the ground: (1) that the adjudication is not in conformity with the terms of this act, or that the workers' compensation judge committed any other error of law; (2) that the findings of fact and adjudication was unwarranted by sufficient, competent evidence or was procured by fraud, coercion, or other improper conduct of any party in interest. The board may, upon cause shown, extend the time provided in this article for taking such appeal or for the filing of an answer or other pleading.

(b) If a timely appeal is filed by a party in interest pursuant to clause (a), any other party may file a cross-appeal within fourteen days of the date on which the first appeal was filed or within the time prescribed by clause (a), whichever period last expires.

(c) The board shall hear the appeal on the record certified by the workers' compensation judge's office. The board shall affirm the workers' compensation judge adjudication, unless it shall find that the adjudication is not in compliance with section 422(a) and the other provisions of this act.

Sec 424 Whenever an appeal shall be based upon an alleged error of law, it shall be the duty of the board to grant a hearing thereon. The board shall fix a time and place for such hearing, and shall serve notice thereof on all parties in interest.

As soon as may be after such hearing, the board shall either sustain or reverse the referee's award or disallowance of compensation, or make such modification thereof as it shall deem proper.

Sec 425 If on appeal it appears that the referee's award or disallowance of compensation was capricious or caused by fraud, coercion, or other improper conduct by any party in interest, the board may, grant a hearing de novo before the board, or one or more of its members or remand the case for rehearing to any referee. If the board shall grant a hearing de novo, it shall fix a time and place for same, and shall notify all parties in interest.

As soon as may be after any hearing by the board, it shall in writing state the findings of fact, whether those of the referee or its own, which are basic to its decision and award or disallow compensation in accordance with the provisions of this act.

Sec 426 The board, upon petition of any party and upon cause shown, may grant a rehearing of any petition upon which the board has made an award or disallowance of compensation or other order or ruling, or upon which the board has sustained or reversed any action of a referee; but such rehearing shall not be granted more than eighteen months after the board has made such award, disallowance, or other order or ruling, or has sustained or reversed any action of the referee. Provided, however, That nothing contained in this section shall limit or restrict the right of the board, or a referee to review, modify, set aside, reinstate, suspend, or terminate, an original or supplemental agreement, or an award in accordance with the provisions of section four hundred thirteen of this article.

Sec 428 Whenever the employer, who has accepted and complied with the provisions of section three hundred five, shall be in default in compensation payments for thirty days or more, the employe or dependents entitled to compensation thereunder may file a certified copy of the agreement and the order of the department approving the same or of the award or order with the prothonotary of the court of common pleas of any county, and the prothonotary shall enter the entire balance payable under the agreement, award or order to be payable to the employe or his dependents, as a judgment against the employer or insurer liable under such agreement or award. Where the compensation so payable is for a total and permanent disability, the judgment shall be in the amount of thirty thousand dollars less such amount as the employer shall have actually paid pursuant to such agreement or award. Such judgment shall be a lien against property of the employer or insurer liable under such agreement or award and execution may issue thereon forthwith.

Whenever, after an injury, any employe or his dependents shall have entered into a compensation agreement with an employer, who has not accepted or complied with the provisions of section three hundred five, or shall file a claim petition against such employer, he may file a certified copy thereof with the prothonotary of the court of common pleas of any county. The prothonotary shall enter the amount stipulated in any such agreement or claimed in any such claim petition as judgment against the employer, and where the amount so stipulated or claimed is for total and permanent disability, such judgment shall be in the sum of thirty thousand dollars. If the agreement be approved by the department, or compensation awarded as claimed in the petition, the amount of compensation stipulated in the agreement or claimed in the petition shall be a lien, as of the date when the agreement or petition was filed with the prothonotary. Pending the approval of the agreement or the award of compensation, no other lien which may be attached to the employer's property during such time shall gain priority over the lien of such agreement or award; but no execution shall issue on any compensation judgment before the approval of the agreement or the award of compensation on the said petition.

If the agreement be disapproved, or, after hearing, compensation shall be disallowed, the employer may file, with the prothonotary of any county in which the petition or agreement is on record as a judgment, a certified copy of the disapproval of the agreement or disallowance of compensation, and it shall be the duty of such prothonotary to strike off the judgment.

If the amount of compensation claimed be disallowed, but another amount awarded, the compensation judgment shall be a lien to the extent of the award, as of the date of filing the petition with the prothonotary, with the same effect as to other liens and the same disability to issue execution thereon as if the compensation claimed had been allowed. In such cases the prothonotary shall make such modification of the record as shall be appropriate.

If the compensation payable under any agreement or award upon which judgment has been entered under the provisions of this section shall be modified, suspended, reinstated, or terminated by a supplemental agreement executed under the provisions of section four hundred and eight, or by an award or order made under the provisions of section four hundred and thirteen, any party to such judgment, at any time after such

agreement has been approved by the department or after the expiration of the time allowed for an appeal from the award or order, may file with the prothonotary of the court of common pleas of any county in which the judgment is on record a certified copy of such supplemental agreement, award, or order and it shall thereupon be the duty of the prothonotary to modify, suspend, reinstate, or satisfy such judgment in accordance with the terms of such supplemental agreement, award, or order.

Execution may issue by first filing with the prothonotary an affidavit that there has been a default in payments of compensation due on any judgment for compensation, entered prior to the approval of the compensation agreement, or an award on petition, as soon as such agreement shall have been approved by the department or such award made as evidenced by the approval of the board of the award or by a certified copy thereof.

Execution shall in all cases be for the amount of compensation and interest thereon due and payable up to the date of the issuance of said execution, with costs, and further execution may issue from time to time as further compensation shall become due and payable until full amount of the judgment with costs shall have actually been paid.

Sec 429 If any party against whom a compensation agreement, award, or other order fixing the compensation payable under this act has been filed of record in any county of this Commonwealth in accordance with the provisions of section four hundred and twenty-eight of this article, or against whom judgment has been entered by the prothonotary of the court of common pleas of any county on any award or order of the board or a referee, shall, at any time, present to the department receipts or copies thereof, certified by any referee, showing the payment of compensation as required by the agreement or award in full to the date of presentation to the referee, the department shall issue a certificate to such party, in the form prescribed, stating the extent to which the judgment on the agreement or award has been reduced. Upon the presentation of such certificate to the prothonotary of the court of common pleas of any county in which such agreement or award has been filed of record as a judgment, or in which judgment on an award has been entered by the prothonotary of the court of common pleas, it shall be the prothonotary's duty to mark such judgment satisfied to the extent of the payments so certified, and, upon the presentation to such prothonotary of a certificate issued by the board under the provisions of section three hundred and seventeen of this act, it shall be the duty of the prothonotary to mark such judgment fully satisfied.

Sec 430 (a) The lien of any judgment entered upon any award shall not be divested by any appeal.

(b) Any insurer or employer who terminates, decreases or refuses to make any payment provided for in the decision without filing a petition and being granted a supersedeas shall be subject to a penalty as provided in section 435, except in the case of payments terminated as provided in section 434.

Sec 431 The cost of the prothonotary for entering the amount of compensation as provided in this act, or making a modification of the record, or marking the judgment satisfied, shall be allowed, taxed, and collected as upon a confession of judgment on a judgment note.

Sec 434 A final receipt, given by an employe or dependent entitled to compensation under a compensation agreement notice or award, shall be prima facie evidence of the termination of the employer's liability to pay compensation under such agreement notice or award: Provided, however, That a referee designated by the department may, at any time within two years from the date to which payments have been made, set aside a final receipt, upon petition filed with the department, or on the department's own motion, if it be shown that all disability due to the injury in fact had not terminated. Where, however, a person is receiving benefits pursuant to the act of June 28, 1935 (P.L. 477, No. 193), referred to as the Heart and Lung Act, the two-year period within which a referee may set aside a final receipt upon petition filed with the

department, or upon the department's own motion, shall not begin to run until the expiration of the receipt of benefits pursuant to the Heart and Lung Act.

[Editor's Note: Text as amended by Act 1974-56.]

Sec 434 A final receipt, given by an employe or dependent entitled to compensation under a compensation agreement notice or award, shall be prima facie evidence of the termination of the employer's liability to pay compensation under such agreement notice or award: Provided, however, That a referee designated by the department may, at any time within three years from the date to which payments have been made, set aside a final receipt, upon petition filed with the department, or on the department's own motion, if it be shown that all disability due to the injury in fact had not terminated.

[Editor's Note: Text as amended by Act 1974-263.]

Sec 435 (a) The department shall establish and promulgate rules and regulations consistent with this act, which are reasonably calculated to:

(i) expedite the reporting and processing of injury cases,

(ii) insure full payment of compensation when due,

(iii) expedite the hearing and determination of claims for compensation and petitions filed with the department under this act,

(iv) provide the disabled employe or his dependents with timely notice and information of his or their rights under this act,

(v) explain and enforce the provisions of this act.

(b) If it appears that there has not been compliance with this act or rules and regulations promulgated thereunder the department may, on its own motion give notice to any persons involved in such apparent noncompliance and schedule a hearing for the purpose of determining whether there has been compliance. The notice of hearing shall contain a statement of the matter to be considered.

(c) The board shall establish rules of procedure, consistent with this act, which are reasonably calculated to expedite the hearing and determination of appeals to the board and to insure full payment of compensation when due.

(d) The department, the board, or any court which may hear any proceedings brought under this act shall have the power to impose penalties as provided herein for violations of the provisions of this act or such rules and regulations or rules of procedure:

(i) Employers and insurers may be penalized a sum not exceeding ten per centum of the amount awarded and interest accrued and payable: Provided, however, That such penalty may be increased to fifty per centum in cases of unreasonable or excessive delays. Such penalty shall be payable to the same persons to whom the compensation is payable.

(ii) Any penalty or interest provided for anywhere in this act shall not be considered as compensation for the purposes of any limitation on the total amount of compensation payable which is set forth in this act.

(iii) Claimants shall forfeit any interest that would normally be payable to them with respect to any period of unexcused delay which they have caused.

(e) The department shall furnish to persons adversely affected by occupational disease appropriate counseling services, vocational rehabilitation services, and other supportive services designed to promote employability to the extent that such services are available and practical.

Sec 436 The secretary, any referee, and any member of the board shall have the power to issue subpoenas to require the attendance of witnesses and/or the production of books, documents, and papers pertinent to any hearing. Any witness who refuses to obey such summons or subpoenas, or who refuses to be sworn or affirmed to testify, or who is guilty of any contempt after notice to appear, may be punished as for contempt of court, and, for this purpose, an application may be made to any court of common pleas within whose territorial jurisdiction the offense was committed, for which purpose such court is hereby given jurisdiction.

Sec 437 The board, department and any referee shall have the power to conduct any investigation which may be deemed necessary in any matter properly before them. Such investigations may be made by the board or referee personally, or by any officer or employe of the department, or by any inspector of the department, or by any person or persons authorized by law. Every inspector and employe of the department is hereby empowered and directed to conduct any investigation authorized by this act, at the request of the board, department or any referee, with the consent of the secretary.

Sec 438 (a) An employer shall report all injuries received by employes in the course of or resulting from their employment immediately to the employer's insurer. If the employer is self-insured such injuries shall be reported to the person responsible for management of the employer's compensation program.

(b) An employer shall report such injuries to the Department of Labor and Industry by filing directly with the department on the form it prescribes a report of injury within forty-eight hours for every injury resulting in death, and mailing within seven days after the date of injury for all other injuries except those resulting in disability continuing less than the day, shift, or turn in which the injury was received. A copy of this report to the department shall be mailed to the employer's insurer forthwith.

(c) Reports of injuries filed with the department under this section shall not be evidence against the employer or the employer's insurer in any proceeding either under this act or otherwise. Such reports may be made available by the department to other State or Federal agencies for study or informational purposes.

Sec 439 Every employer shall keep a record of each injury to any of his employes as reported to him or of which he otherwise has knowledge. Such record shall include a description of the injury, a statement of any time during which the injured person was unable to work because of the injury, and a description of the manner in which the injury occurred. These records shall be available for inspection by the department or by any governmental agency at reasonable times.

Sec 440 (a) In any contested case where the insurer has contested liability in whole or in part, including contested cases involving petitions to terminate, reinstate, increase, reduce or otherwise modify compensation awards, agreements or other payment arrangements or to set aside final receipts, the employe or his dependent, as the case may be, in whose favor the matter at issue has been finally determined in whole or in part shall be awarded, in addition to the award for compensation, a reasonable sum for costs incurred for attorney's fee, witnesses, necessary medical examination, and the value of unreimbursed lost time to attend the proceedings: Provided, That cost for attorney fees may be excluded when a reasonable basis for the contest has been established by the employer or the insurer.

(b) If counsel fees are awarded and assessed against the insurer or employer, then the workers' compensation judge must make a finding as to the amount and the length of time for which such counsel fee is payable based upon the complexity of the factual and legal issues involved, the skill required, the duration of the proceedings and the time and effort required and actually expended. If the insurer has paid or tendered payment of compensation and the controversy relates to the amount

of compensation due, costs for attorney's fee shall be based only on the difference between the final award of compensation and the compensation paid or tendered by the insurer.

Sec 441 (a) If any insurer licensed to transact the business of workmen's compensation insurance within this Commonwealth repeatedly or unreasonably fails to pay promptly compensation for which it is liable or fails or refuses to submit any report or to pay any assessment made under this act, the secretary may recommend to the Insurance Commissioner that the license of the company to transact such business be revoked, or suspended setting forth in detail the reasons for his recommendation. The Insurance Commissioner shall thereupon furnish a copy of the secretary's report to the insurer and shall set a date for public hearing, at which both the insurer and the secretary shall be afforded an opportunity to present evidence. If, after the hearing, the commissioner is satisfied that the insurer has failed to live up to his obligations under this act, he shall promptly revoke or suspend its license.

(b) If any employer who is subject to this act as an approved self-insurer repeatedly or unreasonably fails to pay promptly compensation for which it is liable or fails or refuses to submit any report or to pay any assessment made under this act, the secretary may revoke or suspend the privilege granted to the employer to carry its own risk and require it to insure its liability. The secretary shall not take such action against any employer until the employer has been notified in writing of the charges made against it and has been given an opportunity to be heard before the secretary in answer to the charges.

(c) Any person, not an insurer or self-insurer, engaged in the business of adjusting or servicing injury cases for the payment of compensation under this act shall register with the Department of Labor and Industry as a condition of conducting such business and shall furnish such reports of its activities as may be required by rules and regulations of the department. If any person engaged in such business repeatedly or unreasonably fails to provide such services promptly with the result that compensation is not paid promptly, the secretary may revoke or suspend the privilege of conducting such business. The secretary shall not take such action against such person until such person has been notified in writing of the charges made against it by the secretary and has been given an opportunity to be heard before the secretary in answer to the charges. Proceedings for revocation of the privilege of conducting such service or adjustment business shall not relieve any insurer or self-insurer who has engaged in the services of such person from its responsibility under this act or from its liability to revocation under this section.

Sec 442 All counsel fees, agreed upon by claimant and his attorneys, for services performed in matters before any workers' compensation judge or the board, whether or not allowed as part of a judgment, shall be approved by the worker's compensation judge or board as the case may be, providing the counsel fees do not exceed twenty per centum of the amount awarded.

In cases where the efforts of claimant's counsel produce a result favorable to the claimant but where no immediate award of compensation is made, such as in cases of termination or suspension, the hearing official shall allow or award reasonable counsel fees, as agreed upon by claimant and his attorneys, without regard to any per centum. In the case of compromise and release settlement agreements, no counsel fees shall exceed twenty per centum of the workers' compensation settlement amount.

Sec 443 (a) If, in any case in which a supersedeas has been requested and denied under the provisions of section 413 or section 430, payments of compensation are made as a result thereof and upon the final outcome of the proceedings, it is determined that such compensation was not, in fact, payable, the insurer who has made such payments shall be reimbursed therefor. Application for reimbursement shall be made to the department on forms prescribed by the department and furnished by the insurer. Applications may be assigned to a workmen's compensation referee for a hearing and determination of eligibility for reimbursement pursuant to this act. An appeal shall lie in the manner and on the grounds provided in section 423 of this act, from any allowance or disallowance of reimbursement under this section.

(b) There is hereby established a special fund in the State Treasury, separate and apart from all other public moneys or funds of this Commonwealth, to be known as the Workmen's Compensation Supersedeas Fund. The purpose of this fund shall be to provide moneys for payments pursuant to subsection (a), to include reimbursement to the Commonwealth for any such payments made from general revenues. The department shall be charged with the maintenance and conservation of this fund. The fund shall be maintained by annual assessments on insurers and self-insurers under this act, including the State Workmen's Insurance Fund. The department shall make assessments and collect moneys pursuant to this section of the act. Assessments shall be based on the ratio that such insurer's or self-insurer's payments of compensation bear to the total compensation paid in the year preceding the year of assessment. The total amount to be assessed shall be one hundred percent of the amount reimbursed to insurers and self-insurers in the preceding year pursuant to this section, except that the first annual assessment made under this act shall be in the amount of two hundred fifty thousand dollars ($250,000). The department shall give notice to every insurer and self-insurer under this act, including the State Workmen's Insurance Fund, of the amount assessed against such insurer, self-insurer or the State Workmen's Insurance Fund on or before June 30 of the year following the year upon which the assessment is based: Provided, That notice of the first annual assessment under this act shall be given to every insurer and self-insurer under this act, including the State Workmen's Insurance Fund, within ninety days of the effective date of this amending act. Payment of assessments shall be made to the department within thirty days of receipt of notice of the amount assessed, unless the department specifies on the notices sent to all insurers and self-insurers an installment plan of payment, in which case each such insurer shall pay each installment on or before the date specified therefore by the department within fifteen days after the receipt of such notice, the insurer or self-insurer against which such assessment has been made may file with the department objections setting out in detail the grounds upon which the objector regards such assessment to be excessive, erroneous, unlawful, or invalid. The department, after notice to the objector, shall hold a hearing upon such objections. After such hearing, the department shall record its findings on the objections and shall transmit to the objector, by registered or certified mail, notice of the amount, if any, charged against it in accordance with such findings, which amount or any installment thereof then due, shall be paid by the objector within ten days after receipt of notice of the findings.

No suit or proceeding shall be maintained in any court for the purpose of restraining or in anywise delaying the collection or payment of any assessment made under this subsection but every insurer or self-insurer against which an assessment is made shall pay the same as provided in subsection (b) of this section. Any insurer or self-insurer making any such payment may, at any time within two years from the date of payment, sue the Commonwealth in an action at law to recover the amount paid, or any part thereof, upon the ground that the assessment was excessive, erroneous, unlawful, invalid, in whole or in part, provided objections, as hereinbefore provided, were filed with the department, and payment of the assessment was made under protest either as to all or part thereof. In any action for recovery of any payments made under this section, the claimant shall be entitled to raise every relevant issue of law, but the findings of fact made by the department, pursuant to this section, shall be prima facie evidence of the facts therein stated. If it is finally determined in any such action that all or any part of the assessment for which payment was made under protest was excessive, erroneous, unlawful, or invalid, the department shall make a refund to the claimant out of the appropriation specified in subsection (c) as directed by the court.

(c) The department shall keep a record of the manner in which it shall have computed the amount assessed against every insurer or self-insurer. Such records shall be open to inspection by all interested parties. The determination of such assessments and the records and data upon which the same are made, shall be considered prima facie correct; and in any proceeding instituted to challenge the reasonableness or correctness of any assessment under this section, the party challenging the same shall have the burden of proof. The fund shall be subject to audit by the Auditor General and a copy of the report of the audit furnished to assessed insurers and self-insurers upon request. The Secretary of Labor and Industry shall be the administrator of the fund and shall

have the power to dispense and disburse moneys from the fund for the purpose of payments made pursuant to this section. All moneys in the fund as are required to carry out the purposes of this section are hereby specifically appropriated to the Department of Labor and Industry. The State Treasurer shall be custodian of the fund. Disbursements of moneys pursuant to this section shall be upon final adjudication of requests for payments pursuant thereto.

Sec 444 No person who is qualified for or is receiving compensation under this act, shall, with respect to the same period, receive compensation under The Pennsylvania Occupational Disease Act: Provided, however, That any person may pursue, in the alternative, a claim for compensation under this act and a claim for compensation under The Pennsylvania Occupational Disease Act.

Sec 445 Annual reports of compensation paid by insurers, self-insurers and the State Workmen's Insurance Fund shall be made on a calendar year basis to the department not later than April 15 of the following year, except that for the year 1974 reports shall be filed within sixty days of the effective date of this amending act. Nothing in this act shall be construed to preclude insurers from filing its annual report required herein in substantially the same form as its annual report to the Insurance Department.

Sec 446 (a) There is hereby created a special fund in the State Treasury, separate and apart from all other public moneys or funds of this Commonwealth, to be known as the Workmen's Compensation Administration Fund. The purpose of this fund shall be to finance the Prefund Account established in section 909(a) and the operating and administrative expenses of the Department of Labor and Industry, including the Workmen's Compensation Appeal Board and staff, but not the State Workmen's Insurance Fund, in the direct administration of The Pennsylvania Workmen's Compensation Act and The Pennsylvania Occupational Disease Act including:

(1) wages and salaries of employes for services performed in the administration of these acts;

(2) reasonable travel expenses for employes while engaged in official business; and

(3) moneys expended for office rental, equipment rental, supplies, equipment, repairs, services, postage, books, and periodicals.

(b) The fund shall be maintained by no more than one (1) annual assessment payable in any calendar year on insurers and self-insurers under this act, including the State Workers' Insurance Fund. After the initial term, budgeted expenses shall be approved by the General Assembly on a fiscal year basis. Thereafter, the department shall make assessments and collect moneys based on the ratio that such insurer's or self-insurer's payments of compensation bear to the total compensation paid in the preceding calendar year in which the assessment is made. The total amount assessed shall be the approved budget. If on January 31, there exists in the administration fund any money in excess of one hundred thirty-three per centum of the current budget the following fiscal year's assessment shall be reduced by an amount equal to that excess amount.

(c) The department shall give notice to every insurer and self-insurer under this act, including the State Workmen's Insurance Fund, of the amount assessed against such insurer, self-insurer, or the State Workmen's Insurance Fund on or before November 30 of each year. Payment of assessments shall be made to the department on or before January 31 of the next year unless the department specifies on the notices sent to all insurers and self-insurers an installment plan of payment, in which case each such insurer shall pay each installment on or before the date specified therefore by the department: Provided, That notice of the initial assessment under this act shall be given to every insurer and self-insurer under this act, including the State Workmen's Insurance Fund, within ninety days of the effective date of this amendatory act. Payment of the initial assessments shall be made within thirty days of the mailing of said assessments.

If the General Assembly fails to approve the department's budget for the purposes of this act, by the last day of November, the department shall assess insurers, self-insurers and the State Workmen's Insurance Fund on the basis of that last approved operating budget. At such time as the General Assembly approves the proposed budget the department shall have the authority to make an adjustment in the assessments to reflect the approved budget. If the General Assembly fails to approve the department's budget prior to July 1 of any fiscal year, moneys in the fund are hereby appropriated to the department for the purposes of this act.

Within fifteen days after the receipt of such notice, the insurer or self-insurer against which such assessment has been made may file with the department objections setting out in detail the grounds upon which the objector regards such assessment to be excessive, erroneous, unlawful, or invalid. The department, after notice to the objector, shall hold a hearing upon such objections. After such hearing, the department shall record its findings on the objections and shall transmit to the objector, by registered or certified mail, notice of the amount, if any, charged against it in accordance with such findings, which amount or any installment thereof then due, shall be paid by the objector within ten days after receipt of notice of the findings. If any payment prescribed by this subsection is not made as aforesaid, the secretary of the department may recommend to the Insurance Commissioner that appropriate action be taken against the insurer or self-insurer, including revocation or suspension of the company's license to transact business in the Commonwealth.

No suit or proceeding shall be maintained in any court for the purpose of restraining or in anywise delaying the collection or payment of any assessment made under this subsection but every insurer or self-insurer against which an assessment is made shall pay the same as provided in subsection (c) of this section. Any insurer or self-insurer making any such payment may, at any time within two years from the date of payment, sue the Commonwealth in an action at law to recover the amount paid, or any part thereof, upon the ground that the assessment was excessive, erroneous, unlawful, invalid, in whole or in part, provided objections, as hereinbefore provided, were filed with the department, and payment of the assessment was made under protest either as to all or part thereof. In any action for recovery of any payments made under this section, the claimant shall be entitled to raise every relevant issue of law, but the findings of fact made by the department, pursuant to this section, shall be prima facie evidence of the facts therein stated. If it is finally determined in any such action that all or any part of the assessment for which payment was made under protest was excessive, erroneous, unlawful, or invalid, the department shall make a refund to the claimant out of the fund, as directed by the court.

The department shall keep a record of the manner in which it shall have computed the amount assessed against every insurer or self-insurer. Such records shall be open to inspection by all interested parties. The determination of such assessments and the records and data upon which the same are made, shall be considered prima facie correct; and in any proceeding instituted to challenge the reasonableness or correctness of any assessment under this section, the party challenging the same shall have the burden of proof.

(d) The Secretary of Labor and Industry shall be the administrator of the fund and shall have power to dispense and disburse moneys from the fund for the above purposes at his discretion. All moneys in the fund as are required to carry out the purposes of this act are hereby specifically appropriated to the Department of Labor and Industry for the use in the administration of this act from July 1, 1975 until June 30, 1976. Thereafter, annual appropriations shall be made. Estimates of the amounts to be expended from time to time shall however be submitted by the Secretary of Labor and Industry to the Governor for his approval or disapproval as in the case of other appropriations made to administrative departments, boards, and commissions. The State Treasurer shall be the custodian of the fund. It shall however be unlawful for the State Treasurer to honor any requisition for the expenditure of any moneys from the fund by the Secretary of Labor and Industry in excess of estimates approved by the Governor. The fund shall be audited by the Auditor General annually and a copy of the report of the audit furnished to assessed insurers and self-insurers upon request.

(e) Annual reports of the total compensation paid by insurers, self-insurers, and the State Workmen's Insurance Fund shall be made on a calendar year basis to the department not later than April 15 of the following year: Provided, That reports for the calendar year 1974 shall be filed within sixty days of the effective date of this amending act. Nothing in this act shall be construed to preclude insurers from filing its annual report required therein in substantially the same form as its annual report to the Insurance Department.

(f) Contributions to the fund created by this act, at the rates specified by this act, shall be allowed in full by the Insurance Commissioner and the insurers shall be permitted to fund on an immediate and prospective basis for these costs.

(g) For the purposes of this section the terms "compensation" and "total compensation" shall include wage loss indemnity and payments for medical expenses under this act and under "The Pennsylvania Occupational Disease Act."

(h) Until such time as a sufficient cash balance shall exist in the Workmen's Compensation Administration Fund to meet promptly the expenses of the Commonwealth payable from such fund, the State Treasurer is hereby authorized and directed, from time to time, to transfer to the Workmen's Compensation Administration Fund, if the same be deficient, from the General Fund, such sums as the Governor shall direct. Any sums so transferred shall be available for the purposes for which the fund to which they are transferred is appropriated by law. Such transfers shall be made hereunder upon warrant of the State Treasurer upon requisition of the Governor.

(i) In order to reimburse the General Fund for such transfers, an amount equal to that transferred from the General Fund during any fiscal period shall be retransferred to the General Fund from the Workmen's Compensation Administration Fund in such amounts and at such times as the Governor shall direct, but in no event later than 30 days after the end of such fiscal period. Such transfers shall be made hereunder upon warrant of the State Treasurer upon requisition of the Governor.

(j) The moneys in the General Fund and in the Workmen's Compensation Administration Fund are hereby specifically appropriated for transfer from time to time as provided for in this act.

Sec 447 (a) There is hereby created an advisory council, to be known as the Pennsylvania Workers' Compensation Advisory Council. The council shall be comprised of eight members, with four members being employe representatives and four members being employer representatives. The Secretary of the Department of Labor and Industry shall be an ex officio member. The members of such council shall be appointed as follows: one employe representative and one employer representative by the President pro tempore of the Senate, one employe representative and one employer representative by the Speaker of the House of Representatives, one employe representative and one employer representative by the Minority Leader of the Senate and one employe representative and one employer representative by the Minority Leader of the House of Representatives. The members of the council shall select one of their number to be chairman.

(b) (1) The council may hold hearings, receive testimony, solicit and receive comments from interested parties and the general public and shall have full access to information relating to the administration of this act by the Department of Labor and Industry. The council shall not have access to confidential medical information pertaining to individual claimants, but may develop statistical studies and surveys concerning aspects of incidence of injuries, claims management, litigation and adherence to the provisions of this act and the Occupational Disease Act.

(2) The council shall review annually any requests for funding by the department and any assessments against employers or insurers related thereto and provide a report to the Governor, the secretary and the General Assembly regarding the appropriateness of such requests.

(3) The council shall review proposed legislation and regulations pertaining to this act and provide comment at least quarterly to the Governor, the secretary and the General Assembly on the effects of such proposals.

(4) The council shall provide to the Governor, the secretary and the General Assembly, on an annual basis, a report on the activities of the council, making recommendations concerning needed improvements in the workers' compensation system and the administration of the system. The report under this paragraph shall be made during the General Assembly's consideration of the General Appropriations Act for the succeeding fiscal year. The report shall be due no later than May 1.

(5) The council shall make recommendations to the secretary regarding quality and cost-effective health care.

(6) The council shall review the annual accessibility study required by section 306(f.1)(3)(iv) and shall make recommendations to the secretary regarding the need for new allowances for health care providers.

(7) The council shall make recommendations to the secretary regarding the certification of coordinated care organizations and the approval of utilization review organizations and persons qualified to perform peer review.

(8) The council shall consult with health care providers and professional associations representing health care providers with regard to its recommendations under paragraphs (5), (6) and (7).

(c) The members of the advisory council, once appointed, shall serve a term of two years and until their successors have been appointed. Members shall serve without compensation, but shall be entitled to be reimbursed for all necessary expenses incurred in the discharge of their duties. The secretary shall provide facilities and clerical and professional support as needed by the council in the performance of its duties. The compensation of such staff and the amounts allowed them and to members of the council for traveling and other council expenses shall be deemed part of the expenses incurred in connection with the administration of this act.

Sec 448 (a) An insurer issuing a workers' compensation and employers' liability insurance policy shall offer, upon request, as part of the policy or by endorsement, deductibles optional to the policyholder for benefits payable under the policy, subject to approval by the commissioner and subject to underwriting by the insurer consistent with the principles in clause (b). The commissioner shall promulgate at least three (3) plans with varying deductible options, the least amount of which shall be no less than one thousand dollars ($1,000) nor more than two thousand five hundred dollars ($2,500). The commissioner's authority to promulgate any such plans shall not preclude an insurer from negotiating a deductible in excess of the largest deductible plan herein authorized, subject to approval by the commissioner and subject to underwriting by the insurer consistent with the principles in clause (b).

(b) The following standards shall govern the commissioner's promulgation and an insurer's offer of deductible plans:

(1) Claimants' rights are properly protected and claimants' benefits are paid without regard to any such deductible.

(2) Appropriate premium reductions reflect the type and level of any deductible approved by the commissioner and selected by the policyholder.

(3) Premium reductions for deductibles are determined before application of any experience modification, premium surcharge or premium discount.

(4) Recognition is given to policyholder characteristics, including size, financial capabilities, nature of activities and number of employes.

(5) If the policyholder selects a deductible, the policyholder is liable to the insurer for the deductible amount in regard to benefits paid for compensable claims.

(6) The insurer pays all of the deductible amount applicable to a compensable claim to the person or provider entitled to benefits and then seeks reimbursement from the policyholder for the applicable deductible amount.

(7) Failure to reimburse deductible amounts by the policyholder to the insurer is treated under the policy in the same manner as nonpayment of premiums.

(c) An insurer issuing a workers' compensation and employers' liability insurance policy may offer an endorsement for deductible or retrospective rating plans for groups of five (5) or more employers, subject to approval by the commissioner and subject to underwriting by the insurer consistent with the principles in clause (b).

(d) The following standards shall govern the commissioner's authorization of an insurer's offer of a group deductible or retrospective plan endorsement:

(1) Individual workers' compensation and employers' liability insurance policies will be issued for each member of the group.

(2) Each member will be held jointly and severally liable for the payment of premiums or deductible amounts with regard to benefits paid for compensable claims of the group as a whole.

Sec 449 (a) Nothing in this act shall impair the right of the parties interested to compromise and release, subject to the provisions herein contained, any and all liability which is claimed to exist under this act on account of injury or death.

(b) Upon or after filing a petition, the employer or insurer may submit the proposed compromise and release by stipulation signed by both parties to the workers' compensation judge for approval. The workers' compensation judge shall consider the petition and the proposed agreement in open hearing and shall render a decision. The workers' compensation judge shall not approve any compromise and release agreement unless he first determines that the claimant understands the full legal significance of the agreement. The agreement must be explicit with regard to the payment, if any, of reasonable, necessary and related medical expenses. Hearings on the issue of a compromise and release shall be expedited by the department, and the decision shall be issued within thirty days.

(c) Every compromise and release by stipulation shall be in writing and duly executed, and the signature of the employe, widow or widower or dependent shall be attested by two witnesses or acknowledged before a notary public. The document shall specify:

(1) the date of the injury or occupational disease;

(2) the average weekly wage of the employe as calculated under section 309;

(3) the injury, the nature of the injury and the nature of disability, whether total or partial;

(4) the weekly compensation rate paid or payable;

(5) the amount paid or due and unpaid to the employe or dependent up to the date of the stipulation or agreement or death and the amount of the payment of disability benefits then or thereafter to be made;

(6) the length of time such payment of benefits is to continue;

(7) in the event of a lien for subrogation under section 319, the total amount of compensation paid or payable which should be allowed to the employer or insurer;

(8) in the case of death:

(i) the date of death;

(ii) the name of the widow or widower;

(iii) the names and ages of all children;

(iv) the names of all other dependents; and

(v) the amount paid or to be paid under section 307 and to whom payment is to be made;

(9) a listing of all benefits received or available to the claimant;

(10) a disclosure of the issues of the case and the reasons why the parties are agreeing to the agreement; and

(11) the fact that the claimant is represented by an attorney of his or her own choosing or that the claimant has been specifically informed of the right to representation by an attorney of his or her own choosing and has declined such representation.

(d) The department shall prepare a form to be utilized by the parties for a compromise and release of any and all liability under this act in accordance with the stipulation requirements of this section, and it shall issue such rules and regulations necessary for it and the board to enforce the procedure allowed by this section. No compromise and release shall be considered for approval unless a vocational evaluation of the claimant is completed and filed with the compromise and release and made a part of the record: Provided, however, That this requirement may be waived by mutual agreement of the parties or by a determination of a workers' compensation judge as inappropriate or unnecessary. The vocational evaluation shall be completed:

(1) by a qualified vocational expert approved by the department; or

(2) by the department on a fee-for-service basis.

Nothing in this clause shall serve to impose an obligation of liability or responsibility regarding vocational rehabilitation on either party or to require the implementation of vocational rehabilitation.

Sec 450 (a) Any employer and the recognized or certified and exclusive representative of its employe may agree by collective bargaining to establish certain binding obligations and procedures relating to workers' compensation: Provided, however, That the scope of the agreement shall be limited to:

(1) benefits supplemental to those provided in sections 306 and 307;

(2) an alternative dispute resolution system which may include, but is not limited to, arbitration, mediation and conciliation;

(3) the use of a limited list of providers for medical treatment for any period of time agreed upon by the parties;

(4) the use of a limited list of impartial physicians;

(5) the creation of a light duty, modified job or return to work program;

(6) the adoption of twenty-four-hour medical coverage; and

(7) the establishment of safety committees; and

(8) a vocational rehabilitation or retraining program.

(b) Nothing contained in this section shall in any manner affect the rights of an employer or its employes in the event that the parties to a collective bargaining agreement refuse or fail to reach agreement concerning the matters referred to in clause (a). In the event a municipality and its police or fire employes fail to agree by collective bargaining concerning matters referred to in clause (a), nothing in this section shall be binding upon the municipality or its police or fire employes as a result of an arbitration ruling or award.

(c) Nothing in this section shall allow any agreement that diminishes an employe's entitlement to benefits as otherwise set forth in this section. Any agreement in violation of this provision shall be null and void.

(d) (1) Determinations rendered as a result of an alternative dispute resolution procedure shall remain in force during a period in which the employer and a recognized or certified exclusive collective bargaining representative are renegotiating a collective bargaining agreement.

(2) Upon the expiration of an agreement which contains a provision for an alternative dispute resolution procedure for workers' compensation claims, the resolution of claims relating to injuries sustained as a result of a work-related accident or occupational disease may, if the agreement so provides, be subject to the terms and conditions set forth in the expired agreement until the employer and a recognized or certified exclusive bargaining representative agree to a new agreement.

(3) Upon the termination of an agreement which is not subject to renegotiation and upon severance of the employment relationship, the employer and employes shall become fully subject to the provisions of this act to the same extent that they were prior to the implementation of the agreement.

Sec 451 Insurers, including the State Workers' Insurance Fund, are authorized to provide, on a voluntary basis, to sole proprietors, partners of a partnership or members of a limited liability company, workers' compensation insurance equivalent to that which employers provide to employes which insure their liability under Article III. For the purposes of computing the premium charge, the wages of a sole proprietor, partner or member shall be at least equal to the minimum payroll for a corporate officer, and no more than the maximum payroll for a corporate officer, as established by underwriting rules approved by the Insurance Department. If an injury is compensable under the terms of this coverage, it shall be a rebuttal presumption that the wages of the injured individual are at least equal to minimum payroll for a corporate officer for the purposes of calculating his average weekly wage and paying benefits under sections 306 and 307.

ARTICLE V
General Provisions

Sec 501 No claim or agreement for legal services or disbursements in support of any demand made or suit brought under the provisions of article two of this act shall be an enforceable lien against the amount to be paid as damages, or be valid or binding in any respect, unless the same be approved in writing by the judge presiding at the trial, or, in case of settlement without trial, by a judge of the common pleas court of the county in which the injury occurred.

No claim or agreement for legal services or disbursements in support of any claim for compensation, or in preparing any agreement for compensation, under article three of this act, shall be an enforceable lien against the amount to be paid as compensation, or be valid or binding in any other respect, unless the same be approved by the board. Any such claim or agreement shall be filed with the department, which shall, as soon as may be, notify the person by whom the same was filed of the board's approval or disapproval thereof, as the case may be.

After the approval as herein required, if the employer be notified in writing of such claim or agreement for legal services and disbursements, the same shall be a lien against any amount thereafter to be paid as damages or compensation: Provided, however, That where the employe's compensation is payable by the employer in periodical instalments, the board shall fix, at the time of approval the proportion of each instalment to be paid on account of legal services and disbursements, and the board may upon application made to it commute the sum awarded for legal services and disbursements.

Sec 502 If any provision of this act shall be held by any court to be unconstitutional, such judgment shall not affect any other section or provision of this act, except that articles two and three are hereby declared to be inseparable and as one legislative thought, and if either article be declared by such court void or inoperative in an essential part, so that the whole of such article must fall, the other article shall fall with it and not stand alone.

Sec 503 Nothing in this act shall affect or impair any right of action which shall have accrued before this act shall take effect, except that, because litigation is now pending as to the constitutionality of the compensation schedules contained in the amendment of this act, approved the fourth day of June, one thousand nine hundred and thirty-seven (Pamphlet Laws, one thousand five hundred fifty-two), the department is hereby authorized to approve agreements or supplemental agreements, and the board and referees are hereby authorized to make awards effectuating agreements, compromising disputes between employers and employes or their dependents, as to the amount of compensation payable in cases arising out of injuries occurring between January first, one thousand nine hundred and thirty-eight and the effective date of this reenactment of this act, if such agreements or supplemental agreements provide for, or the parties to cases pending before the board or referees have agreed to, the payment of compensation at the rates and for the periods specified in this reenactment of this act.

ARTICLE VI
Additional Coverages

Sec 601 (a) In addition to those persons included within the definition of the word "employe" as defined in section 104, "employe" shall also include:

(1) members of volunteer fire departments or volunteer fire companies, including any paid fireman who is a member of a volunteer fire company and performs the services of a volunteer fireman during off-duty hours, who shall be entitled to receive compensation in case of injuries received while actively engaged as firemen or while going to or returning from a fire which the fire company or fire department attended including travel from and the direct return to a fireman's home, place of business or other place where he shall have been when he received the call or alarm or while participating in instruction fire drills in which the fire department or fire company shall have participated or while repairing or doing other work about or on the fire apparatus or buildings and grounds of the fire company or fire department upon the authorization of the chief of the fire company or fire department or other person in charge or while answering any emergency calls for any purpose or while riding upon the fire apparatus which is owned or used by the fire company or fire department or while performing any other duties of such fire company or fire department as authorized by the municipality or while performing duties imposed by section 15, act of April 27, 1927 (P.L. 465, No. 299), referred to as the Fire and Panic Act;

(2) all members of volunteer ambulance corps of the various municipalities who shall be and are hereby declared to be employes of such municipality for the purposes of this act who shall be entitled to receive compensation in the case of injuries received while actually engaged as ambulance corpsmen or while going to or returning from any fire, accident, or other emergency which such volunteer ambulance corps shall attend including travel from and the direct return to a corpsman's home, place of business or other place where he shall have been when he received the call or alarm; or while participating in ambulance corps of which they are members; or while repairing or doing other work about or on the ambulance apparatus or buildings and grounds of such ambulance corps upon the authorization of the corps president or other person in charge; or while answering any emergency call for any purpose or while riding in or upon the ambulance apparatus owned by the ambulance corps of which they are members at any time or while performing any other duties of such ambulance corps as are authorized by the municipality;

(3) members of volunteer rescue and lifesaving squads of the various municipalities who shall be and are hereby declared to be employes of such municipalities for the purposes of this act and who shall be entitled to receive compensation in the case of injuries received while actually engaged as a rescue and lifesaving squad member attending to any emergency to which that squad has been called or responded including travel from and the direct return to a squad person's home, place of business or other place where he shall have been when he received the call or alarm or while participating in rescue and lifesaving drills in which the squad is participating; while repairing or doing other work about or on the apparatus, buildings and grounds of such rescue and lifesaving squad upon the authorization of the chief or other person in charge; or while riding in or upon the apparatus of the rescue and lifesaving squad and at any time while performing any other duties authorized by the municipality;

(4) volunteer members of the State Parks and Forest Program, who shall be declared to be employes of the Commonwealth for the purposes of this act, shall be entitled to receive compensation in case of injuries received while actually engaged in performing any duties in connection with the volunteers in the State Parks and Forest Program;

(5) Pennsylvania Deputy Game Protectors are hereby defined to be employes of the Commonwealth for all the purposes of this act and shall be entitled to receive compensation in case of injuries received while actually engaged in the performance of duties as a Pennsylvania Deputy Game Protector whether employed by the Game Commission or otherwise;

(6) all special waterways patrolmen are hereby declared to be employes of the Commonwealth for all purposes of this act and shall be entitled to receive compensation in case of injuries received while actually engaged in the performance of their duties as special waterways patrolmen whether actually receiving compensation from the Pennsylvania Fish Commission or not;

(7) all forest firefighters are hereby declared to be employes of the Commonwealth for the purposes of this act and shall be entitled to receive compensation in case of injuries received while actually engaged in the performance of their duties as forest firefighters or forest fire protection employes which duties shall include participation in the extinguishing of forest fires or traveling to and from forest fires or while performing any other duties relating to forest fire protection as authorized by the Secretary of Environmental Resources or his designee.

(8) All volunteer members of hazardous materials response teams who shall be and are hereby declared to be employes of the Commonwealth agency, county, municipality, regional hazardous materials organization, volunteer service organization, corporation, partnership or of any other entity which organized the hazardous materials response team for the primary purpose of responding to the release of a hazardous material. All such volunteer members of hazardous materials response teams shall be entitled, under this act, to receive compensation in the case of injuries received while actively engaged as hazardous materials response team members or while going to or returning from any emergency response incident or accident which the hazardous materials response team attended, including travel from and direct return to a team member's home, place of business or other place where the member shall have been when the member received the call or alarm to respond to the emergency incident or accident; or while participating in hazardous materials response drills or exercises in which the hazardous materials response team is participating; or while repairing or doing other work about or on the hazardous materials response team apparatus or buildings and grounds of the hazardous materials response team upon the authorization of the chief of the hazardous materials response team or other person in charge; or while answering any emergency calls for any purpose; or while riding upon the hazardous materials response team apparatus which is owned or used by the hazardous materials response team in responding to an emergency or drill or with the express permission of the chief of the team; or while performing any other duties of such hazardous materials response team as authorized by the Commonwealth agency, county, municipality, regional hazardous materials organization, volunteer service organization, corporation, partnership or any other entity which duly organized the hazardous materials response team.

(9) All local coordinators of emergency management, as defined in 35 Pa.C.S. § 7502 (relating to local coordinator of emergency management), of the various municipalities who shall be and are hereby declared to be employes of such municipalities for the purposes of this act and who shall be entitled to receive compensation in the case of injuries received while actually engaged as local coordinator of emergency management at any emergency to which he has been called or responded, including travel from and the direct return to his home, place of business or other place where he shall have been when he received the call or alarm or while performing any other duties authorized by the municipality.

(10) An employe who, while in the course and scope of his employment, goes to the aid of a person and suffers injury or death as a direct result of any of the following:

(i) Preventing the commission of a crime, lawfully apprehending a person reasonably suspected of having committed a crime or aiding the victim of a crime. For purposes of this clause, the terms "crime" and "victim" shall have the same meanings as given to them in section 103 of the act of November 24, 1998 (P.L. 882, No. 111), known as the "Crime Victims Act."

(ii) Rendering emergency care, first aid or rescue at the scene of an emergency.

(b) In all cases where an injury which is compensable under the terms of this act is received by an employe as defined in this section, there is an irrebuttable presumption that his wages shall be at least equal to the Statewide average weekly wage for the purpose of computing his compensation under sections 306 and 307.

(c) Whenever any member of a volunteer fire company, volunteer fire department, volunteer ambulance corps, or rescue and lifesaving squad is injured in the performance of duties in State Parks and State Forest Land, they shall be deemed to be an employe of the Department of Environmental Resources.

(d) The term "municipality" when used in this article shall mean all cities, boroughs, incorporated towns, or townships.

Sec 602 (a) The following shall apply:

(1) A municipality or an area of a municipality which receives emergency services pursuant to a contract, standing agreement or arrangement from a volunteer emergency service provider located in a host municipality shall reimburse the host municipality under the provisions of either clause (2) or (3).

(2) Reimbursement under clause (1) shall be for a portion of the cost of the workers' compensation premiums covering the members of the volunteer emergency service provider. The appropriate portion of the cost shall be determined as follows:

(i) Determine the population ratio of the municipality or the area of the municipality receiving emergency services to the entire population (host municipality and the municipality or the area of the municipality) receiving emergency services from the volunteer emergency service provider. The following shall apply:

(A) No segment of the population of the municipality or area of the municipality receiving emergency services may be included in more than one service area for purposes of calculating the ratio under subclause (i).

(B) If the first due area for fire protection services and the first due area for emergency medical services differ within a municipality or an area of a municipality receiving emergency services, then the ratio under subclause (i) shall be calculated using the first due area for fire protection services.

(ii) Multiply the ratio under subclause (i) by the host municipality's entire cost of the workers' compensation premium for covering members of the volunteer emergency service provider.

(3) The host municipality and the municipality receiving the emergency services may agree to share the cost on some other basis.

(b) As used in this section:

"Emergency services" shall mean any of the following:

(i) Fire protection services.

(ii) Ambulance services.

(iii) Emergency medical services.

(iv) Quick response services.

(v) Emergency management services.

(vi) Rescue and lifesaving services.

(vii) Hazardous material support services.

(viii) Certified hazardous materials response services.

"Host municipality" shall mean a municipality that is responsible for workers' compensation premiums for an emergency service provider located within its corporate boundaries.

"Volunteer emergency service provider" shall mean any of the following:

(i) A volunteer fire company.

(ii) A volunteer ambulance corps.

(iii) A volunteer quick response service.

(iv) A volunteer rescue and lifesaving squad.

(v) A volunteer hazardous materials support team.

(vi) A volunteer certified municipal emergency management coordinator.

(vii) A volunteer hazardous materials response team.

ARTICLE VII
Insurance Rates

Sec 701 It is the intent of the General Assembly:

(1) To protect policyholders and the public against the adverse effect of excessive, inadequate or unfairly discriminatory rates.

(2) To encourage, as the most effective way to produce rates that conform to the standards of paragraph (1), independent action by and reasonable price competition among insurers.

(3) To provide formal regulatory controls for use if price competition fails.

(4) To authorize cooperative action among insurers in the ratemaking process and to regulate such cooperation in order to prevent practices that tend to bring about monopoly or to lessen or destroy competition.

(5) To provide rates that are responsive to competitive market conditions and to improve the availability of insurance in this Commonwealth.

Sec 702 This article applies to the classification of risks, underwriting rules, expenses, losses and profits for insurance of employers and employes under this act, for insurance under the Occupational Disease Act and for insurance with respect to the Commonwealth as to liability under the Federal Coal Mine Health and Safety Act of 1969 (Public Law 91-173, 30 U.S.C. § 801 et seq.).

Sec 703 As used in this article:

"Classification system" or "classification" means the plan, system or arrangement for recognizing differences in exposure to hazards among industries, occupations or operations of insurance policyholders.

"Department" means the Insurance Department of the Commonwealth.

"Experience rating" means a rating procedure utilizing past insurance experience of the individual policyholder to forecast future losses by measuring the policyholder's loss experience against the loss experience of policyholders in the same classification to produce a prospective premium credit, debit or unity modification.

"Market" means the interaction in this State between buyers and sellers of workers' compensation and employers' liability insurance within this Commonwealth pursuant to the provisions of this article.

"Provision for claim payment" means historical aggregate losses projected through development to their ultimate value and through trending to a future point in time, but excluding all loss adjustment or claim management expenses, other operating expenses, assessments, taxes, and profit or contingency allowances.

"Rate" or "rates" means rate of premium, policy and membership fee or any other charge made by an insurer for or in connection with a contract or policy of insurance of the kind to which this article applies.

"Rating organization" means one or more organizations situate within this Commonwealth, subject to supervision and to examination by the commissioner and approved by the commissioner as adequately equipped to perform the functions specified in this article on an equitable and impartial basis.

"Statistical plan" means the plan, system or arrangement used in collecting data.

"Supplementary rate information" means any manual or plan of rates, statistical plan, classification system, rating schedule, minimum premium policy fee, rating rule, rate-related underwriting rule and any other information, not otherwise inconsistent with the purposes of this article, prescribed by rule of the commissioner.

"Supporting information" means the experience and judgment of the filer and the experience or data of other insurers or organizations relied on by the filer, the interpretation of any statistical data relied on by the filer, description or methods used in making the rates and any other similar information required to be filed by the commissioner.

Sec 704 (a) The following standards shall apply to the making and use of rates under this article:

(1) Rates may not be:

(i) excessive or inadequate as defined under this article; or

(ii) unfairly discriminatory.

(2) A rate may not be held to be excessive unless it is likely to produce a long-run profit that is unreasonably high in relation to the risk undertaken and the services to be rendered.

(3) A rate may not be held to be inadequate unless:

(i) it is unreasonably low for the insurance provided and continued use of it would endanger solvency of the insurer; or

(ii) the rate is unreasonably low for the insurance provided and the use of the rate by the insurer has had or, if continued, will have the effect of destroying competition or of creating monopoly.

(b) In determining whether rates comply with standards under subsection (a), due consideration shall be given to:

(1) Past and prospective loss experience within and outside this Commonwealth in accordance with sound actuarial principles.

(2) Catastrophe hazards.

(3) A reasonable margin for underwriting profit and contingencies.

(4) Dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders or members or subscribers.

(5) Past and prospective expenses, both countrywide and those specially applicable to this Commonwealth.

(6) Investment income earned or realized by insurers both from their unearned premium and from their loss reserve funds.

(7) All relevant factors within and outside this Commonwealth in accordance with sound actuarial principles.

(c) As to the kinds of insurance to which this article applies, the systems of expense provisions included in the rates for use by an insurer or group of insurers may differ from those of any other insurers or groups of insurers to reflect the requirements of the operating methods of the insurer or group of insurers.

Sec 705 (a) Each authorized insurer shall file with the commissioner all rates and supplementary rate information and all changes and amendments thereof made by it for use in this Commonwealth by the date they become effective. Each rating organization shall file with the commissioner a filing for the provision for claim payment and such other filings as are authorized pursuant to this article. The Secretary of Labor and Industry shall be a member of the board of directors or governing body of any rating organization.

(b) An insurer may not make or issue a contract or policy of insurance of the kind to which this article applies, except in accordance with the filings which are in effect for the insurer as provided in this article.

Sec 706 Each filing and any supporting information filed under this article shall, as soon as filed, be open to public inspection. Copies may be obtained by any person on request and upon payment of a reasonable charge.

Sec 707 (a) Each workers' compensation insurer shall be a member of a rating organization. Each workers' compensation insurer shall adhere to the policy forms filed by the rating organization.

(b) (1) Every workers' compensation insurer shall adhere to the uniform classification system and uniform experience rating plan filed with the commissioner by the rating organization to which it belongs: Provided, That the system and plan have been approved by the commissioner as part of the approval of the rating organization's most recent filing for the provision for claim payment.

(2) (i) Subject to the conditions of this paragraph, an insurer may develop subclassifications of the uniform classification system upon which a rate may be made.

(ii) Any subclassification developed under subparagraph (i) shall be filed with the rating organization and the commissioner thirty (30) days prior to its use.

(iii) If the insurer fails to demonstrate that the data produced under a subclassification can be reported in a manner consistent with the rating organization's uniform statistical plan and classification system, the commissioner shall disapprove the subclassification.

(c) Every workers' compensation insurer shall record and report its workers' compensation experience to a rating organization as set forth in the rating organization's uniform statistical plan approved by the commissioner.

(d) (1) Subject to the approval of the commissioner, a rating organization shall develop and file rules reasonably related to the recording and reporting of data pursuant to the uniform statistical plan, the uniform experience rating plan and the uniform classification system.

(2) Every workers' compensation insurer shall adhere to the approved rules and experience rating plan in writing and reporting its business.

(3) An insurer shall not agree with any other insurer or with a rating organization to adhere to rules which are not reasonably related to the recording and reporting of data pursuant to the uniform classification system or the uniform statistical plan.

(e) The experience rating plan shall have as a basis:

(1) reasonable eligibility standards;

(2) adequate incentives for loss prevention;

(3) sufficient premium differential so as to encourage safety; and

(4) predictive accuracy.

(f) (1) The uniform experience rating plan shall be the exclusive means of providing prospective premium adjustment based upon measurement of the loss producing characteristics of an individual insured.

(2) An insurer may file a rating plan that provides for retrospective premium adjustments based upon an insured's past experience.

(g) The commissioner shall promulgate a plan by which all insurers writing workers' compensation insurance in this Commonwealth shall grant premium discounts or assess premium surcharges to employers who do not qualify for the uniform experience rating plan in accordance with the following:

(1) An employer who has not experienced a compensable employe lost-time injury during the most recent two-year period for which statistics are available shall receive a discount of five per centum on the amount of the workers' compensation insurance premium.

(2) An employer who has experienced two or more compensable employe lost-time injuries during the most recent two-year period for which statistics are available shall be assessed a surcharge of five per centum on the amount of the workers' compensation insurance premium.

(3) The premium discounts or premium surcharges established under this section shall be made on an annual basis but shall not be cumulative: Provided, however, That an employer is entitled to receive the premium discount provided by this section in addition to any other reductions or deviations in the insurance premiums available to all other nonexperienced-rated employers in the same classification. For any annual workers' compensation premium, an employer shall not receive a premium discount of more than five per centum and shall not be required to pay a surcharge of more than five per centum.

(4) Insurers writing workers' compensation insurance in this Commonwealth may file a schedule rating plan based upon defined risk characteristics. Prior approval of this plan by the commissioner is required.

For purposes of this clause, "employer" shall include a municipality or a municipal pool.

Sec 708 (a) The commissioner may investigate and determine whether or not rates in this Commonwealth under this article are excessive, inadequate or unfairly discriminatory.

(b) In any such investigation and determination the commissioner shall follow the procedures specified in sections 709 and 710.

Sec 709 (a) (1) Except as provided in subsection (d), the commissioner shall review each workers' compensation insurance filing made by a rating organization or an insurer as soon as reasonably possible after the filing has been made in order to determine whether it meets the requirements

of this article. No filing for the provision for claim payment shall become effective prior to its approval by the commissioner unless the commissioner fails to approve or disapprove the filing within the time period described in subsection (b)(1) or any extension of that period under subsection (b)(2).

(2) Notwithstanding the provisions of paragraph (1), any insurer filing for loss adjustment or claim management expenses, other operating expenses, assessments, taxes and profits or contingency allowances filed with the commissioner with respect to the period after December 1, 1994, shall not be subject to the commissioner's approval unless such insurer's rates are found to be in violation of sections 704 and 711.

(b) (1) The effective date of each filing under this article shall be the date specified in the filing. The effective date of the filing may not be earlier than thirty (30) days after the date the filing is received by the commissioner or the date of receipt of the information furnished in support of the filing if such supporting information is required by the commissioner.

(2) The period during which the filing may not become effective may be extended by the commissioner for an additional period not to exceed one hundred fifty (150) days if the commissioner gives written notice within the period described in paragraph (1) to the insurer or rating organization which made the filing that the commissioner needs additional time for the consideration of the filing. No filing shall be made effective for any period prior to the later of the proposed effective date or the expiration of an extension by the commissioner pursuant to this paragraph.

(3) Upon written application by an insurer or rating organization, the commissioner may authorize a filing which the commissioner has reviewed to become effective before the expiration of the period described in paragraph (1).

(4) A filing shall be deemed to meet the requirements of this article unless disapproved by the commissioner within the period described in paragraph (1) or any extension thereof.

(c) (1) Subject to approval or disapproval under subsection (b), a rating organization shall file with the commissioner:

(i) On an annual basis, workers' compensation rates and rating plans that are limited to provision for claim payment.

(ii) Each workers' compensation policy form to be used by its members.

(iii) The uniform classification system.

(iv) The uniform experience rating plan and related rules.

(v) Any other information that the commissioner requests relevant to the foregoing and is otherwise entitled to receive under this article.

(2) Notwithstanding any other provisions of this article, the commissioner may approve or disapprove any filing by a rating organization without determining whether a reasonable degree of competition exists within the market.

(d) If the loss cost provision in a schedule of workers' compensation rates for specific classifications of risks filed by an insurer does not differ from the provision for claim payment contained in the schedule of workers' compensation rates for those classifications filed by a rating organization

under subsection (c) and approved pursuant to the provisions of this article, then the schedule of rates filed by the insurer shall not be subject to subsection (b) but shall become effective for the purposes of section 705.

(e) Notwithstanding subsection (d), the commissioner may investigate and evaluate all workers' compensation filings to determine whether the filings meet the requirements of this article.

(f) Notwithstanding the provisions of section 705, the commissioner may require any insurer or rating organization to comply with the requirements of subsection (b) if the commissioner has found pursuant to section 710 that a reasonable degree of competition does not exist within the workers' compensation insurance market.

Sec 710 (a) If the commissioner finds after a hearing that a rate is not in compliance with section 704 or that a rate had been set in violation of section 713, the commissioner shall order that its use be discontinued for any policy issued or renewed after a date specified in the order, and the order may prospectively provide for premium adjustment of any policy then in force. Except as provided in subsection (b), the order shall be issued within thirty (30) days after the close of the hearing or within a reasonable time extension as fixed by the commissioner. The order shall expire one (1) year after its effective date unless rescinded earlier by the commissioner.

(b) (1) Pending a hearing, the commissioner may order the suspension prospectively of a rate filed by an insurer and reimpose the last previous rate in effect if the commissioner has reasonable cause to believe that:

(i) an insurer is in violation of section 704;

(ii) unless the order of suspension is issued, certain insureds will suffer irreparable harm;

(iii) the hardship insureds will suffer absent the order of suspension outweighs any hardship the insurer would suffer if the order of suspension were to issue; and

(iv) the order of suspension will cause no substantial harm to the public.

(2) In the event the commissioner suspends a rate under this subsection, the commissioner must, unless waived by the insurer, hold a hearing within fifteen (15) working days after issuing the order suspending the rate. In addition, the commissioner must make a determination and issue the order as to whether or not the rate should be disapproved within fifteen (15) working days after the close of the hearing.

(c) (1) At any hearing to determine compliance with section 704, pursuant to subsection (a), the commissioner may first determine whether a reasonable degree of competition exists within the market and shall give a ruling to that effect. All insurers operating within such market shall have the burden of establishing that a reasonable degree of competition exists within that market. The commissioner shall consider all relevant factors in determining the competitiveness of the market, including:

(i) the number of insurers actively engaged in providing coverage;

(ii) market shares;

(iii) changes in market shares; and

(iv) ease of entry.

(2) If the commissioner determines that a reasonable degree of competition does not exist in the market, any insurer designated by the commissioner shall have the burden of justifying its rate in such market.

(3) All determinations made by the commissioner shall be on the basis of findings of fact and conclusions of law.

(4) If the commissioner disapproves a rate, the disapproval shall take effect not less than fifteen (15) days after his order and the last previous rate in effect for the insurer shall be reimposed for a period of one (1) year unless the commissioner approves a rate under subsection (d) or (e).

(d) Within one (1) year after the effective date of a disapproval order, no rate adopted to replace one disapproved under such order may be used until it has been filed with the commissioner and not disproved within thirty (30) days thereafter.

(e) Whenever an insurer has no legally effective rates as a result of the commissioner's disapproval of rates, the commissioner shall, on the insurer's request, specify interim rates for the insurer that are high enough to protect the interests of all parties and may order that a specified portion of the premiums be placed in a special reserve established by the insurer. When new rates become legally effective, the commissioner shall order the specially reserved funds or any overcharge in the interim rates to be distributed appropriately to the insureds or insurer, as the case may be, except that refunds to policyholders that are minimal may not be required.

Sec 711 (a) (1) If the commissioner finds after hearing that competition is not an effective regulator of the rates charged or that a substantial number of companies are competing irresponsibly through the rates charged or that there are widespread violations of this article, the commissioner may adopt a rule requiring that any subsequent changes in the rates or supplementary rate information be filed with the commissioner at least thirty (30) working days before they become effective.

(2) In the event that the waiting period is imposed pursuant to paragraph (1), the commissioner may extend the waiting period for a period not to exceed thirty (30) additional working days by written notice to the filer before the first thirty-day period expires.

(b) In the event that the commissioner has entered an order pursuant to paragraph (1) of subsection (a), the commissioner may require the filing of supporting data as the commissioner deems necessary for the proper functioning of the rate monitoring and regulating process. The supporting data shall include:

(1) the experience and judgment of the filer and, to the extent the filer wishes or the commissioner requires, the experience and judgment of other insurers or rate service organizations;

(2) the filer's interpretation of any statistical data relied upon;

(3) a description of the actuarial and statistical methods employed in setting the rate; and

(4) any other relevant matters required by the commissioner.

(c) A rule adopted under this section shall expire not more than one year after issue. The commissioner may renew it for an additional one-year period after a hearing and appropriate findings under this section.

(d) Whenever a filing is not accompanied by the information as the commissioner has required under subsection (a), the commissioner may so inform the insurer and the filing shall be deemed to be made when the information is furnished.

Sec 712 (a) No rating organization shall provide any service relating to the rates of any insurance subject to this article, and no insurer shall utilize the service of such organization for those purposes unless the organization has obtained a license pursuant to this article.

(b) No rating organization shall refuse to supply services for which it is licensed in this Commonwealth to any insurer authorized to do business in this Commonwealth and offering to pay the fair and usual compensation for the services.

Sec 713 (a) As used in this section, the word "insurer" includes two or more affiliated insurers:

(1) under common management; or

(2) under common controlling ownership or under other common effective legal control and in fact engaged in joint or cooperative underwriting, investment management, marketing, servicing or administration of their business and affairs as insurers.

(b) An insurer or rating organization may not:

(1) monopolize or attempt to monopolize or combine or conspire with any other person or persons or monopolize the business of insurance of any kind, subdivision, or class thereof;

(2) agree with any other insurer or rating organization to charge or adhere to any rate, although insurers and rating organizations may continue to exchange statistical information;

(3) make any agreement with any other insurer, rating organization or other person to unreasonably restrain trade;

(4) make any agreement with any other insurer, rating organization or other person where the effect of the agreement may be substantially to lessen competition in the business of insurance of any kind, subdivision or class; or

(5) make any agreement with any other insurer or rating organization to refuse to deal with any person in connection with the sale of insurance.

(c) An insurer may not acquire or retain any capital stock or assets of or have any common management with any other insurer if such acquisition, retention or common management substantially lessens competition in the business of insurance of any kind, subdivision or class.

(d) A rating organization or member or subscriber thereof may not interfere with the right of any insurer to make its rates independently of that rating organization or to charge rates different from the rates made by that rating organization.

(e) Except as required under section 707, a rating organization may not have or adopt any rule or exact any agreement, formulate or engage in any program which would require any member, subscriber or other insurer to:

(1) utilize some or all of its services;

(2) adhere to its rates, rating plan, rating systems or underwriting rules; or

(3) prevent any insurer from acting independently.

Sec 714 Any rate in violation of section 713 shall be disapproved by the commissioner in accordance with the procedures prescribed in section 710, and each violator shall be subject to the penalties provided in section 720.

Sec 715 The commissioner may maintain an action to enjoin any violation of section 713.

Sec 716 Notwithstanding any other provision of this article, upon written application of an insurer stating its reasons therefor, accompanied by the written consent of the insured or prospective insured, filed with and approved by the commissioner, a rate in excess of that provided by a filing otherwise applicable may be used as to any specific risk.

Sec 717 (a) Each rating organization and every insurer to which this article applies which makes its own rates shall provide within this Commonwealth reasonable means whereby any person aggrieved by the application of its rating system may be heard in person or by the person's authorized representative on the person's written request to review the manner in which such rating system has been applied in connection with the insurance afforded the aggrieved person. For the purposes of this section, "reasonable means" shall include at least the following:

(1) A committee to hear the appeals of aggrieved persons which is comprised of an equal number of representatives of employers and insurers.

(2) If travel is required for the aggrieved person to be heard in person, reimbursement to the aggrieved person for reasonable travel expenses.

(b) If the rating organization or insurer fails to grant or reject the aggrieved person's request within thirty (30) days after it is made, the applicant may proceed in the same manner as if the application had been rejected.

(c) Any party affected by the action of that rating organization or insurer on the request may, within thirty (30) days after written notice of that action, make application in writing for an appeal to the commissioner, setting forth the basis for the appeal and the grounds to be relied upon by the applicant.

(d) The commissioner shall review the application and, if the commissioner finds that the application is made in good faith and that it sets forth on its face grounds which reasonably justify holding a hearing, the commissioner shall conduct a hearing held on not less than ten (10) days' written notice to the applicant and to the rating organization or insurer. The commissioner, after hearing, shall affirm or reverse the action.

Sec 718 (a) Cooperation among rating organizations or among rating organizations and insurers in ratemaking or in other matters within the scope of this article is authorized if the filings resulting from that cooperation are subject to all the provisions of this article which are applicable to filings generally.

(b) The commissioner may review these cooperative activities and practices, and, if after hearing the commissioner finds that any activity or practice is unfair, unreasonable or otherwise inconsistent with this article, the commissioner may issue a written order specifying in what respects that activity or practice is unfair, unreasonable or otherwise inconsistent with this article and requiring the discontinuance of that activity or practice.

Sec 719 (a) A person or organization may not wilfully withhold information from or knowingly give false or misleading information which will affect the rates or premiums chargeable under this article to:

(1) the commissioner; or

(2) any rating organization or any insurer.

(b) A violation of this section shall subject the one who commits that violation to the penalties provided in section 720, and anyone who violates this section with intent to deceive commits perjury, and is subject to prosecution therefor in a court of competent jurisdiction.

Sec 720 (a) Any person, organization or insurer found by the commissioner after notice and hearing to be guilty of a violation of any provision of this article, including a regulation of the commissioner adopted under this article, may be ordered to pay a penalty of five hundred dollars ($500) for each violation. Upon finding such violation to be wilful, the commissioner may impose a penalty of not more than one thousand dollars ($1,000) for each such violation in addition to any other penalty provided by law. The commissioner has the right to suspend or revoke or refuse to renew the license of any person, organization or insurer for violation of any of the provisions of this article.

(b) The commissioner may determine when a suspension or revocation of license will become effective, and the suspension or revocation shall remain in effect for the period fixed by the commissioner unless the commissioner modifies or rescinds the suspension or revocation or until the order upon which the suspension or revocation is based is modified or reversed as the result of an appeal therefrom.

(c) A fine may not be imposed nor a license suspended or revoked by the commissioner except upon written order stating the commissioner's findings made after a hearing held on not less than ten (10) days' written notice to the person, organization or insurer specifying the alleged violation.

Sec 721 All decisions and findings of the commissioner under this article shall be subject to judicial review in accordance with 2 Pa.C.S. (relating to administrative law and procedure).

Sec 722 The commissioner shall report to the General Assembly annually, beginning on December 31, 1993, on the status, operation and procedures for the determination of classification systems as they apply to this article.

ARTICLE VIII
Self-Insurance Pooling

Sec 801 The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Actuarially appropriate loss reserves" shall mean those reserves needed to pay known claims for compensation and expenses associated therewith and claims for compensation incurred but not reported and expenses associated therewith.

"Administrator" means an individual, partnership or corporation engaged by a fund's plan committee to carry out the policies established by the plan committee and to provide day-to-day management of the fund.

"Compensation" includes compensation paid under this act or the Occupational Disease Act.

"Department" means the Department of Labor and Industry of the Commonwealth.

"Employer" means an employer as defined in section 103 of this act or as defined in section 103 of the Occupational Disease Act, where applicable.

"Excess insurance" means insurance purchased from an insurance company appropriately approved or authorized or licensed in this Commonwealth covering losses in excess of an amount established between the group and the insurer up to the limits of coverage set forth in the insurance contract on a specific per occurrence or per accident or annual aggregate basis.

"Fund" means a group self-insurance fund organized by employers to pool workers' compensation liabilities and approved by the department under the authority of this act. A fund shall not be deemed to be an insurer or insurance company and shall not be subject to the provisions of the insurance laws and regulations, except as specifically otherwise provided herein.

"Homogeneous employer" means employers who have been assigned to the same classification series for at least one year or are engaged in the same or similar types of business, including political subdivisions.

"Independent actuary" means a member in good standing of the Casualty Actuarial Society or a member in good standing of the American Academy of Actuaries who has been identified by the Academy as meeting its qualification standards for signing casualty loss reserve opinions. Said actuary must not be an officer, director or employe of the fund or a member of the fund for which he or she is providing reports, certifications or services.

"Insolvent fund" means the inability of a fund to pay its outstanding liabilities as they mature as may be shown either by an excess of its required reserves and other liabilities over its assets or by not having sufficient assets to reinsure all of its outstanding liabilities after paying all accrued claims owed by it.

"Permit" means the document issued by the department to a fund which authorizes the fund to operate as a fund under the provisions of this act.

"Plan committee" means a committee composed of representatives of each employer participating in a fund.

"Political subdivision" means any county, city, borough, incorporated town, township, school district, vocational school district and county institution district, municipal authority or other entity created by a political subdivision pursuant to law.

"Security" means surety bonds, cash, negotiable securities of the United States Government or the Commonwealth or other negotiable securities, such as letters of credit, acceptable to the department which are posted by the fund to guaranty the payment of compensation.

"Surplus" means that amount of moneys found in the trust to be in excess of all fixed costs and incurred losses attributed to the pool net any occurrence or aggregate excess insurance.

"Trust" means a written contract signed by the members of the fund which separates the legal and equitable rights to the moneys held by an independent trustee as a fiduciary for the benefit of employes of employers participating in the fund.

Sec 802 (a) Employers shall be permitted to pool their liabilities under this act and the Occupational Disease Act and their employers' liability through participation in a fund approved by the department.

(b) A group of homogeneous employers may be approved by the department to act as a fund if the proposed group:

(1) Includes five or more homogeneous employers.

(2) Is comprised of at least five members of which each have been employers for at least three years prior to the filing of the group's application.

(3) Has been created in good faith for the purpose of becoming a fund.

(4) Has, except for political subdivisions, an aggregate net worth of the employers participating calculated according to generally accepted accounting principles which equals or exceeds one million dollars ($1,000,000) or such amount as may be adjusted and promulgated annually by the department and published in the Pennsylvania Bulletin to take effect January 1 of each year.

(5) Has a combined annual payroll of fund members multiplied by the rate utilized by the State Workmen's Insurance Fund which is equal to or greater than five hundred thousand dollars ($500,000) as adjusted annually by the percentage increase in the Statewide average weekly wage or such amount as may be adjusted and promulgated annually by the department and published in the Pennsylvania Bulletin to take effect January 1 of each year.

(6) Guarantees benefit levels equal to those required by this act and the Occupational Disease Act.

(7) Demonstrates sufficient aggregate financial strength and liquidity to assure that all obligations under this act and the Occupational Disease Act will be met as required by that act and proposes a plan for the prompt payment of such benefits. Information documenting an individual member's financial strength and liquidity shall be presented to the department upon the department's request or with the application as required by the department.

(8) Executes a trust agreement under which each member agrees to jointly and severally assume and discharge the liabilities arising under this act and the Occupational Disease Act of each and every party to such agreement.

(9) Files with the department the proposed trust agreement.

(10) Provides for excess insurance with retention amounts in such amount as the department deems acceptable on a single accident (single occurrence) and aggregate excess basis. The

department may waive the requirement for one or both types of excess insurance if convinced that the fund's financial strength is sufficient to assure payment of its obligations under this act and the Occupational Disease Act.

(11) Provides security in a form and amount prescribed by the department. This paragraph shall not apply to pools created by and exclusively for political subdivisions or municipalities which self-insure.

(12) Provides letters of intent from prospective fund members and evidence that each prospective member:

(i) Has never defaulted on compensation due under this act or the Occupational Disease Act as an individual self-insurer.

(ii) Has not been delinquent in payment of or canceled for nonpayment of workers' compensation premiums for a period of at least two (2) years prior to application.

(iii) Has not been found to have violated section 305 or 435 or the Occupational Disease Act as an individual self-insurer.

(iv) Has not been and is not in default on or owes money assessed under this act or the Occupational Disease Act.

(13) Provides that the fund will initiate and maintain a loss prevention and safety program of the nature and extent that would be required of members under the provisions of this act, the Occupational Disease Act or regulations promulgated hereunder.

(14) Provides for assessment upon employers participating in the fund to establish and maintain actuarially appropriate loss reserves and a plan for payment of such assessments.

(15) Provides proof of competent personnel and ample facilities within its own organization with respect to claims administration, underwriting matters, loss prevention and safety engineering or presents a contract with a reputable service company to provide such assistance.

(16) Meets the other criteria established by this act or by the department pursuant to regulations promulgated under this act or the Occupational Disease Act.

(c) Each application for approval of a fund shall be accompanied by a nonrefundable fee of one thousand dollars ($1,000), payable to the department, which shall be deposited in the Workmen's Compensation Administration Fund.

Sec 803 (a) (1) The department shall, in accordance with section 802, review, approve or disapprove fund applications under such rules and requirements relating to applications under section 305 and the Occupational Disease Act as may be applicable and such rules and regulations as are specifically adopted with regard to fund applications.

(2) During the pendency of the processing of any fund application, the group of employers shall not operate as a fund.

(b) Permits shall identify an annual reporting period for the fund as established by the department.

Sec 804 All permits issued under this article shall remain in effect unless terminated at the request of the fund or revoked by the department.

Sec 805 (a) If at any time the fund is found to be insolvent, fails to pay any required assessments under this act or the Occupational Disease Act or fails to comply with any provision of this act or the Occupational Disease Act or with any rules promulgated thereunder, the department may revoke its permit after notice and opportunity for a hearing.

(b) In the case of revocation of a permit, the department may require the fund to insure or reinsure all incurred liability with an authorized insurer. All fund members shall immediately obtain coverage required by this act.

Sec 806 (a) Members of said fund shall pay a minimum of twenty-five per centum of their annual assessment into the fund on or before the inception of the fund. The balance of the annual assessments shall be paid to the fund on a monthly, quarterly or semiannual basis as required by the fund's bylaws and approved by the department.

(b) Each member's annual assessment to the fund shall equal such member's annual payroll times the applicable rates utilized by the State Workmen's Insurance Fund minus the premium discount specified in Schedule Y as approved by the commissioner. Dividends may be returned to members in accordance with section 809.

(c) Nothing contained in this section shall preclude the assessment and payment of supplemental assessments as provided in section 810.

Sec 807 After the final permit approval date of the fund, prospective new members of the fund shall submit an application for membership to the fund's plan committee or administrator in a form approved by the department. This application shall include an agreement of joint and several liability as required in section 803. The administrator or plan committee may approve the application for membership pursuant to the bylaws of the fund. The application approved by the fund shall be filed with the department. The fund shall retain the authority to reject any applicant.

Sec 808 (a) Individual members may elect to terminate their participation in a fund or be subject to cancellation by the fund pursuant to the bylaws of the fund for nonpayment of premium or other violations. Any member withdrawing from a fund or member terminated by the fund for nonpayment of assessments shall remain fully obligated for claims incurred during the period of its membership in accord with fund bylaws, including, but not limited to, amounts owed as annual or supplemental assessments. Notice of termination of any participant shall be filed with the fund. The fund shall attach any such notices of termination to the renewal application filed with the department.

(b) The fund shall notify the department immediately if termination of a member causes the fund to fail to meet the requirements of section 802(b). Within fifteen (15) days of the notice of withdrawal or decision to expel, the fund shall advise the department of its plan to bring the fund into compliance with section 802(b). If the plan does not bring the fund into compliance with the requirements, the department shall immediately review and revoke its permit.

(c) The department shall not grant the request of any fund to terminate its permit unless the fund has insured or reinsured all incurred workers' compensation obligations with an authorized insurer under an agreement filed with and approved in writing by the department. These obligations shall include both known claims and expenses associated therewith and claims incurred but not reported and expenses associated therewith. These same requirements shall apply where the department revokes a permit.

Sec 809 Any fund may return to its members dividends based upon the recommendation of an independent actuary. Dividends shall not be returned if the payment of such dividends would impair the fund's ability to meet its obligations under this act or the Occupational Disease Act, nor shall dividends be returned prior

to the beginning of the thirteenth month following the expiration of the preceding annual reporting period. The initial dividend payment for any annual reporting period shall not exceed thirty per centum of the surplus available for the applicable annual reporting period. The fund may, however, seek annual approval for payment of dividends from the surplus remaining from any annual reporting period which has been completed for at least twenty-five months or longer and may include such dividend payments with initial dividend payments from the subsequent annual reporting period.

Sec 810 (a) If the assets of a fund are at any time insufficient to enable the fund to discharge its legal liabilities and other obligations and to maintain the actuarially appropriate loss reserves required of it under section 802(b)(14), the fund shall forthwith make up the deficiency or levy an assessment upon the fund members for the amount needed to make up the deficiency.

(b) In the event of a deficiency in any annual reporting period, such deficiency shall be made up immediately either from surplus from a year other than the current year, assessment of the fund members if ordered by the fund or such alternate method as the department may approve or direct.

(c) If the fund fails to assess its members or to otherwise make up such deficit within thirty (30) days, the department shall order it to do so.

(d) If the fund fails to make the required assessment of its members within thirty (30) days after the department orders it to do so or if the deficiency is not fully made up within sixty (60) days after the date on which such assessment is made or within such longer period of time as may be specified by the department, the fund shall be deemed to be insolvent.

(e) The department shall proceed against an insolvent fund in the same manner as the department would proceed against a self-insurer under Article IX.

(f) In addition, in the event of the liquidation or default of a fund, the department may levy an assessment upon the fund members for such an amount as the department determines to be necessary to discharge all liabilities of the fund, including the reasonable cost of liquidation, and shall deposit such assessments into the Self-Insurance Guaranty Fund for distribution and payment by the Guaranty Fund as provided for in Article IX.

Sec 811 The annual assessment of each fund member shall be based upon the annual payroll of fund members multiplied by the rates as utilized by the State Workmen's Insurance Fund for members minus any premium discounts. A fund may deviate from these rates and establish its own rates with the approval of an independent actuary and the department.

Sec 812 Each fund shall request classifications for its participants from the bureau or bureaus approved by the commissioner and shall utilize those classifications making assessments based upon rates as utilized by the State Workmen's Insurance Fund for such classification except as provided in section 811. The fund shall pay the appropriate bureau a reasonable charge, approved by the commissioner, for this service. The fund may appeal classifications as provided in the applicable sections of the Insurance Company Law of 1921 for other employers.

Sec 813 Each fund may invest any surplus moneys not needed for current obligations in United States Government obligations, United States Treasury notes, investment share accounts in any savings and loan association whose deposits are insured by a Federal agency and certificates of deposit issued by a duly chartered commercial bank. Deposits in savings and loan associations and commercial banks shall be limited to institutions in this Commonwealth and shall not exceed the federally insured amount in any one account. Investments may also be made in any permitted investments of capital or surplus of stock casualty insurance companies set forth in section 602 or 603 of the Insurance Company Law of 1921, as may be authorized by regulation approved by the commissioner.

Sec 814 (a) Funds approved under this article shall purchase excess insurance by reason of any single accident or any single occurrence as provided in section 653 of the Insurance Company Law of 1921 and aggregate excess insurance. The department may waive the requirement for either single accident (single occurrence) or aggregate excess insurance or the requirement for both single accident (single occurrence) and aggregate excess insurance.

(b) A policy of insurance by an insurance carrier may include provisions for aggregate excess insurance in addition to the single accident (single occurrence) excess insurance which is authorized under section 653 of the Insurance Company Law of 1921.

Sec 815 (a) A report shall be prepared by each fund for each annual reporting period and shall be filed with the department and made available to each fund member.

(b) The information contained in the annual report shall include, for each member of the fund and the fund itself:

(1) Summary loss reports.

(2) An annual statement of the financial condition of the fund prepared by a certified public accountant and performed in accordance with generally accepted accounting principles.

(3) Reports of outstanding liabilities showing the number of claims, amounts paid to date and current reserves as certified by an independent actuary.

(4) Such other information as required by regulation of the department as may be applicable to applicants for self-insurance under section 305 and the Occupational Disease Act or regulations in regard to fund applications.

(c) The annual report shall be accompanied by a one thousand dollar evaluation fee.

(d) The department may, at any time, examine the affairs, transactions, accounts, records and assets of a fund, and the fund shall make all such items as are needed for such examination available to the department. The department shall bill the fund for the reasonable costs associated with such examinations.

(e) If at any time there is a change in the fund during an annual reporting period other than as set forth in section 808 that affects the ability of the fund to comply with the requirements of section 802(b), the fund shall notify the department of the change within thirty (30) days after such change.

Sec 816 Each fund shall be assessed annually by the department in a like manner and amount as other insurers or self-insurers are now or hereafter assessed under this act and the Occupational Disease Act and shall pay such assessment in accordance with this act and the Occupational Disease Act. All contributions received in accordance with this section shall be deposited into the appropriate fund as required by the applicable provision of law.

Sec 817 Any group of five (5) homogeneous employers who will provide to the fund an annual volume of premium of at least five hundred thousand dollars ($500,000) may become subscribers as a group to the State Workmen's Insurance Fund for the purpose of insuring therein their liability to those of their employes. Such group shall become legally obligated to pay any employe compensation required by this act because of bodily injury by accident or disease, including death at any time resulting therefrom, sustained by such employe arising out of and in the course of his employment. Such group shall make a written application for subscription for group insurance to the board. Such application shall designate the name of the group subscriber and shall include such information as determined by the board as will allow the board to identify

the employers and to adequately assess risks and premiums to be charged to employers to be insured by the fund under the group subscription.

Sec 818 The department is authorized to promulgate rules and regulations for the administration and enforcement of this article.

Sec 819 If an associate of employers establishes more than one group under this article, the association may organize a single board of trustees to oversee the operations of the several groups: Provided, however, That each of the several groups shall be equally represented on the board.

ARTICLE IX
Self-Insurance Guaranty Fund

Sec 901 The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Account" means the Prefund Account established in section 909(a).

"Compensation" means benefits paid pursuant to sections 306 and 307.

"Defaulted self-insurer" means an employer, other than the Commonwealth and its political subdivisions, that is exempted by the Department of Labor and Industry from the requirement to insure its liability under this act or under section 305 of the act of June 21, 1939 (P.L. 566, No. 284), known as "The Pennsylvania Occupational Disease Act," for claims on injuries or exposures to the hazard of disease which occurred prior to October 30, 1993, and which has failed to pay that liability due to its financial inability or due to its filing for bankruptcy or being declared bankrupt or insolvent.

"Employer" means a self-insured employer or the employer as defined in this act.

"Fiscal year" means the fiscal year of the Commonwealth.

"Guaranty Fund" or "fund" means the Self-Insurance Guaranty Fund established in section 902 for injuries and exposures occurring on or after the establishment of the Self-Insurance Guaranty Fund.

"Prefund claimant" means an employe or a dependent of an employe of a defaulted self-insurer who is entitled to benefits under this act or the act of June 21, 1939 (P.L. 566, No. 284), known as "The Pennsylvania Occupational Disease Act," as the result of injury or exposure to the hazard of disease which occurred prior to October 30, 1993.

"Security" means surety bonds, cash, negotiable securities of the United States Government or the Commonwealth or other negotiable securities, such as letter of credit, acceptable to the department which are posted by the fund to guaranty the payment of workers' compensation benefits.

"Self-insurer" means an employer exempted under section 305 or a group self-insurance fund permitted to operate under Article VIII.

"Workmen's Compensation Administration Fund" means the special fund established in section 446.

Sec 902 (a) (1) There is hereby established a special fund to be known as the Self-Insurance Guaranty Fund.

(2) The fund shall be maintained as two distinct custodial accounts in the State Treasury as separate and distinct accounts subject to the procedures and provisions set forth in this article.

(b) The moneys in each custodial account shall consist of security and assessments, as defined in section 907, and interest accumulated thereon.

(c) The administrator shall establish and maintain the following two distinct and separate custodial accounts. The moneys and other assets in each account are not to be commingled or used to pay claims from the other account.

(1) Custodial account for self-insured employers for the exclusive benefit of claims arising from defaulting individual self-insured employers.

(2) Custodial account for self-insurance pooling as defined under section 801 for the exclusive benefit of claims arising from defaulting members of pooling arrangements.

(d) The secretary shall be the administrator of the fund and shall have the power to collect, dispense and disperse money from the fund.

Sec 903 The fund shall be maintained to make payments to any claimant or his dependents upon the default of the self-insurer liable to pay compensation due under this act and the Occupational Disease Act or costs associated therewith and shall be maintained in an amount sufficient to pay such compensation and costs or reasonably anticipated to be needed by virtue of default by self-insurers.

Sec 904 (a) When a self-insurer fails to pay compensation when due, the department shall determine the reasons for such failure.

(b) If the department determines that the failure to pay compensation is due to the self-insurer's financial inability to pay compensation, the department shall notify the self-insurer of same and direct compensation to be paid within fifteen (15) days of such notice.

(c) If the self-insurer fails to pay the compensation as directed and within the time set forth in this section, the department shall declare the self-insurer in default.

(d) Whenever the department determines that a default has occurred, it shall:

(1) Investigate the circumstances surrounding the default, the amount of security available and the ability of the self-insured to cure the default.

(2) Determine whether the liabilities of the self-insurer for compensation exceed or are less than the security:

(i) If the liabilities are less than the security, the department shall demand the custodian of the security utilize the security to cure the default and the department shall monitor the situation to insure that compensation is paid as due under this act or the Occupational Disease Act.

(ii) If at any time the liabilities exceed or can reasonably be expected to exceed the security, in the opinion of the department, the department may order payment of the security into the fund's appropriate custodial account and shall order payment from the Guaranty Fund, as appropriate, to cure the default and insure that compensation is paid as due under this act or the Occupational Disease Act.

Sec 905 (a) When payments are ordered from the Guaranty Fund's appropriate custodial account, the fund assumes the rights and obligations of the self-insurer under this act or the Occupational Disease Act with regard to the payment of compensation and shall have and may exercise the rights set forth in this section.

(b) The Guaranty Fund shall have the right to:

(1) Institute and prosecute legal action against any self-insurer and each and every member of a fund, jointly and severally, on behalf of the employes of the self-insured employer or fund members' employes and their dependents to require the payment of compensation and the performance of any other obligations of the self-insurer under this act or the Occupational Disease Act.

(2) Appear and represent the Guaranty Fund in any proceedings in bankruptcy involving the self-insurer on whose behalf payments were made, including the ability to appear and move to lift any stay orders affecting payment of compensation.

(3) Obtain, in any manner or by the use of any process or procedure, including, but not limited to, the commencement and prosecution of legal action, reimbursement from a self-insurer and its successors, assigns and estate all moneys paid on account of the self-insurer's obligation assumed by the fund, including, but not limited to, reimbursement for all compensation paid as well as reasonable administrative and legal costs associated with such payment.

(4) Purchase reinsurance and take any and all other action which effects the purpose of the Guaranty Fund.

Sec 906 (a) (1) Security or funds from security demanded and paid to the department under section 904 shall be deposited into the Guaranty Fund.

(2) These funds and interest thereon shall be segregated in individual custodial accounts within the Guaranty Fund by the custodian and maintained solely for the payment of compensation or costs associated therewith upon order of the department to the employes of the defaulting self-insurer providing the security from the appropriate custodial account.

(3) If there are funds from security or interest thereon remaining in the individual account after all outstanding obligations of the insolvent self-insurer have been satisfied and the costs of administration and defense have been paid, such amount as remains shall be returned upon order of the department from the Guaranty Fund individual account to the self-insurer.

(b) Assessments made under section 907 and interest thereon shall be deposited into the Guaranty Fund's appropriate custodial account.

Sec 907 (a) On a date to be determined by the department following the effective date of this article, employers who are self-insurers as of that effective date shall pay an initial assessment of one-half per centum of the compensation paid by each self-insurer in the year preceding the assessment. Self-insurers who, prior to such effective date, were not self-insurers shall pay an assessment based on one-half per centum of their modified manual premium for the twelve (12) months immediately prior to becoming self-insurers.

(b) (1) The department may, in addition to the initial assessment, from time to time, assess each self-insurer a pro rata share of the amounts needed for the fund to carry out the requirements of this article.

(2) Such assessments shall be based on the ratio that each self-insurer's payments of compensation bears to the total compensation paid by all self-insurers in the year preceding the year of assessment.

(3) In no event shall a self-insurer be assessed in any one calendar year more than one per centum of the compensation paid by that self-insurer during the previous calendar year.

(c) A self-insurer which ceases to be a self-insurer shall be liable for any and all assessments made pursuant to this section during the period following the date its authority to self-insure is withdrawn, revoked or surrendered until such time as it has discharged all obligations to pay compensation which arose during the period of time said former self-insurer was self-insured. Assessments of such a former self-insurer shall be based on the compensation paid by the former self-insurer during the preceding calendar year on claims that arose during the period of time said former self-insurer was self-insured.

Sec 908 The department may promulgate rules and regulations for the administration and enforcement of this article.

Sec 909 (a) There is established in the Self-Insurance Guaranty Fund a restricted account known as the Prefund Account. The department shall annually transfer from the Workmen's Compensation Administration Fund to the account an amount up to three million eight hundred thousand dollars ($3,800,000) but not exceeding the sum of all claims for benefits payable under subsection (c).

(b) Deleted by 2001, June 22, P.L. 606, § 3, effective July 1, 2001.

(c) Transfers to the account pursuant to subsection (a) shall be used to pay claims for loss of wages occurring or medical treatment provided after the effective date of this section under sections 306(a), (b), (c) and (f.1) and 307 of this act or under sections 306(a), (b) and (c) and 307 of the act of June 21, 1939 (P.L. 566, No. 284), known as "The Pennsylvania Occupational Disease Act," to a prefund claimant upon exhaustion of the security posted by the liable defaulted self-insurer: Provided, That:

(1) the benefits are payable under a notice of compensation payable, an agreement for compensation or a petition for compensation and the petition, notice or agreement was filed with the department before January 1, 1997;

(2) payments from the account are not used to pay interest, penalties or attorney fees related to the payment of benefits;

(3) payments from the account are used to pay claims for benefits relating to medical treatment under section 306(f.1) of this act that are not covered or not paid for, in whole or in part, by other types of insurance or Federal, State or private benefit programs;

(4) this section shall not be construed to require payment of claims for benefits when transfers to the account pursuant to subsection (a) are insufficient to satisfy claims for benefits by prefund claimants except to the extent required by subsection (e)(1); and

(5) the receipt of benefits under this section is subject to the law in effect as of the effective date of this section and not the date of an award from a petition, a notice of compensation payable or an agreement for compensation.

(d) When payments are made from the account on behalf of a defaulted self-insurer, the department assumes the rights and obligations of the defaulted self-insurer under this act and "The Pennsylvania Occupational Disease Act" with regard to the payment of claims. The department shall have the right to:

(1) Initiate and prosecute legal action against the defaulted self-insurer to require the payment of benefits under this act or "the Pennsylvania Occupational Disease Act."

(2) Obtain, in any manner or by use of any process or procedure, including the commencement and prosecution of legal action, reimbursement from a defaulted self-insurer and its successor, assigns and estate of all payments from the account to its prefund claimants, including reimbursement of all claims for benefits paid as well as reasonable administrative and legal costs associated with the payment.

(e) The following shall apply:

(1) If the department projects that the aggregate payments to prefund claimants pursuant to this section during any one fiscal year may exceed the transfer to the account for that year, the secretary shall order the payment of benefits under sections 306(a), (b) and (c) and 307 at a

percentage of the full amounts payable under this act and "The Pennsylvania Occupational Disease Act." The percentage shall be uniformly applied to all benefits under those sections paid during that fiscal year. The secretary shall adjust that percentage from time to time as is necessary based on updated projections on payment of benefits.

(2) To take action under paragraph (1), the department must provide a minimum of sixty (60) days' notice to the General Assembly of the impending action. The notice must be in the form of a written report of the pending funding shortfall to the chairpersons and the minority chairpersons of the Appropriations Committee and the Labor and Industry Committee of the Senate and the chairpersons and the minority chairpersons of the Appropriations Committee and the Labor Relations Committee of the House of Representatives. The General Assembly may appropriate sufficient funds to the account to continue full payment of benefits to prefund claimants for that fiscal year.

(f) A prefund claimant shall within three years of the effective date of this section or within three years of last receiving benefits from a defaulted self-insurer or its security, whichever occurs later, forward to the department an application for benefits that includes all of the following:

(1) Name of the prefund claimant.

(2) The prefund claimant's Social Security number.

(3) The department claim number of the claim for which benefits are requested, if known.

(4) The prefund claimant's date of birth.

(5) The date of injury giving rise to the claim.

(6) The name of the employer at the time of injury.

(7) If known, the date of receipt of the last payment from the defaulted self-insurer or its security.

(8) The amount of current wages from current employment or self-employment.

(9) A signature certifying that the request for benefits is true and correct and that the prefund claimant is aware of the penalties provided by law for making false statements for the purpose of obtaining benefits.

(10) Any other information required by the department that is relevant in determining the entitlement to or amount of benefits.

(g) Nothing in this section shall be construed to require the department to make wage loss payments to an individual who is currently receiving wages equal to or in excess of the benefit they would receive under this section. Nothing in this section shall be construed to require the department to make a wage loss payment that would result in an individual receiving more in wages and compensation combined than his pre-injury wage.

(h) Applications and other information submitted to the department under this section and section 305 shall not be public records for purposes of the act of June 21, 1957 (P.L. 390, No. 212), referred to as the Right-to-Know Law, and shall not be subject to public disclosure.

ARTICLE X
Health and Safety

Sec 1001 (a) Notwithstanding any other provision of law, an insurer desiring to write workers' compensation insurance in this Commonwealth shall maintain or provide accident and illness prevention services as a prerequisite for a license to write such insurance. Proof of compliance with this section shall be provided to the commissioner. Such services shall be adequate to furnish accident prevention required by the nature of its business or its policyholders' operations and shall include surveys, recommendations, training programs, consultations, analyses of accident causes, industrial hygiene and industrial health services to implement the program of accident prevention services. The insurer, pursuant to its responsibilities under this section shall employ or otherwise make available qualified accident and illness prevention personnel. Such personnel shall meet the qualifications set forth in regulations issued by the department.

(b) A self-insured employer shall maintain an accident and illness prevention program as a prerequisite for retention of its self-insured status. Such program shall be adequate to furnish accident prevention required by the nature of its business and shall include surveys, recommendations, training programs, consultations, analyses of accident causes, industrial hygiene and industrial health services. The self-insured employer pursuant to its responsibilities under this section, shall employ or otherwise make available qualified accident and illness prevention personnel. Such personnel shall meet the qualifications set forth in regulations issued by the department.

(c) The department may conduct inspections to determine the adequacy of the accident prevention services required by this section at least once every two (2) years for each insurer.

(d) Notice that services required by this section are available to the employer from an insurer must appear in no less than ten-point bold type and must accompany each workers' compensation insurance policy delivered or issued for delivery in this Commonwealth.

(e) At least once each year, each insurer must submit to the department detailed information on the type of accident prevention services offered or provided to the insurer's policyholders. The information must include:

(1) The amount of money spent by the insurer on accident prevention services.

(2) The number and qualifications of field safety representatives employed by the insurer.

(3) The number of site inspections performed.

(4) Any accident prevention services for which the insurer contracts.

(5) A breakdown of the premium size of the risks to which the insurer provided services.

(6) Evidence of the effectiveness of and accomplishments in accident prevention.

(f) Failure to maintain or provide the accident prevention services required by this section shall constitute a continuing civil violation subject to a maximum fine of two thousand dollars ($2,000) per day for each day the accident prevention services are not maintained or provided. Each day of noncompliance with this section is a separate violation. All fines recovered under this section shall be paid to the department and deposited by the department into the Workmen's Compensation Administration Fund created by section 446 of this act.

(g) The insurer, the agent, servant or employe of the insurer and the past and present employer and employe members of the safety committee established under section 1002 and any collective bargaining representative shall not be liable on any cause of action or in any proceeding, civil or criminal, arising out of or based upon allegations and pleadings relating to the performance of services under or in compliance with this article. This immunity shall not, however, affect the liability of the employer or the insurer for compensation as otherwise provided in this act. The recommendations, findings and minutes of a safety committee shall not be admissible evidence in any civil action filed on behalf of an employe against a third party regarding any injury incurred in the course and scope of employment.

Sec 1002 (a) An insured employer may make application to the department for the certification of any established safety committee operative within its workplace developed for the purpose of hazard detection and accident prevention. The department shall develop such certification criteria.

(b) Upon the renewal of the employer's workers' compensation policy next following receipt of department certification, the employer shall receive an annual five per centum discount in the rate or rates applicable to the policy if the employer, on a form prescribed by the department, provides annual verification to the department and to the employer's insurer that the safety committee continues to be operative and continues to meet the certification requirements.

ARTICLE XI
Insurance Fraud

Sec 1101 The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Attorney" means an individual admitted by the Pennsylvania Supreme Court to practice law in this Commonwealth.

"Health care provider" means a person licensed or certified pursuant to law to perform health care activities.

"Insurance claim" means a claim for payment or other benefits pursuant to an insurance policy for workers' compensation.

"Insurance policy" means a document setting forth the terms and conditions of a contract of insurance or agreement for workers' compensation.

"Insurer" means a company, association or exchange defined by section 101 of the Insurance Company Law of 1921 and the State Workmen's Insurance Fund, an unincorporated association of underwriting members, a hospital plan corporation, a professional health services plan corporation, a health maintenance organization, a fraternal benefit society, and a self-insured health care entity under the act of October 15, 1975 (P.L. 390, No.111), known as the "Health Care Services Malpractice Act."

"Person" means an individual, corporation, partnership, association, joint-stock company, trust or unincorporated organization. The term includes any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society, beneficial association and any other legal entity engaged or proposing to become engaged, either directly or indirectly, in the business of insurance, including agents, brokers, adjusters and health care plans as defined in 40 Pa.C.S. Chs. 61 (relating to hospital plan corporations), 63 (relating to professional health services plan corporations), 65 (relating to fraternal benefit societies) and 67 (relating to beneficial societies) and the act of December 29, 1972 (P.L. 1701, No. 364), known as the "Health Maintenance Organization Act." For purposes of this article, health care plans, fraternal benefit societies and beneficial societies shall be deemed to be engaged in the business of insurance.

"Statement" means any oral or written presentation or other evidence of loss, injury or expense, including, but not limited to, any notice, statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or doctor records, X-ray, test result or computer-generated documents.

Sec 1102 A person, including, but not limited to, the employer, the employe, the health care provider, the attorney, the insurer, the State Workmen's Insurance Fund and self-insureds, commits an offense if the person does any of the following:

(1) Knowingly and with the intent to defraud a State or local government agency files, presents or causes to be filed with or presented to the government agency a document that contains false, incomplete or misleading information concerning any fact or thing material to the agency's determination in approving or disapproving a workers' compensation insurance rate filing, a workers' compensation transaction or other workers' compensation insurance action which is required or filed in response to an agency's request.

(2) Knowingly and with intent to defraud any insurer presents or causes to be presented to any insurer any statement forming a part of or in support of a workers' compensation insurance claim that

contains any false, incomplete or misleading information concerning any fact or thing material to the workers' compensation insurance claim.

(3) Knowingly and with the intent to defraud any insurer assists, abets, solicits or conspires with another to prepare or make any statement that is intended to be presented to any insurer in connection with or in support of a workers' compensation insurance claim that contains any false, incomplete or misleading information concerning any fact or thing material to the workers' compensation insurance claim.

(4) Engages in unlicensed agent or broker activity as defined by the act of May 17, 1921 (P.L. 789, No. 285), known as "The Insurance Department Act of 1921," knowingly and with the intent to defraud an insurer or the public.

(5) Knowingly benefits, directly or indirectly, from the proceeds derived from a violation of this section due to the assistance, conspiracy or urging of any person.

(6) Is the owner, administrator or employe of any health care facility and knowingly allows the use of such facility by any person in furtherance of a scheme or conspiracy to violate any of the provisions of this section.

(7) Knowingly and with the intent to defraud assists, abets, solicits or conspires with any person who engages in an unlawful act under this section.

(8) Makes or causes to be made any knowingly false or fraudulent statement with regard to entitlement to benefits with the intent to discourage an injured worker from claiming benefits or pursuing a claim.

(9) Knowingly and with the intent to defraud makes any false statement for the purpose of avoiding or diminishing the amount of the payment in premiums to an insurer or self-insurance fund.

(10) Knowingly and with intent to defraud, fails to make the report required under section 311.1.

(11) Knowingly and with intent to defraud, receives total disability benefits under this act while employed or receiving wages.

(12) Knowingly and with intent to defraud, receives partial disability benefits in excess of the amount permitted with respect to the wages received.

Sec 1103 (a) A lawyer may not compensate or give anything of value to a nonlawyer to recommend or secure employment by a client or as a reward for having made a recommendation resulting in employment by a client, except that the lawyer may pay:

(1) the reasonable cost of advertising or written communication as permitted by the rules of professional conduct; or

(2) the usual charges of a not-for-profit lawyer referral service or other legal service organization.

Upon a conviction of an offense under this clause, the prosecutor shall certify the conviction to the disciplinary board of the Supreme Court for appropriate action, including suspension or disbarment.

(b) With respect to a workers' compensation insurance benefit or claim, a health care provider may not compensate or give anything of value to a person to recommend or secure the provider's service to or employment by a patient or as a reward for having made a recommendation resulting in the

provider's service to or employment by a patient, except that the provider may pay the reasonable cost of advertising or written communication as permitted by rules of professional conduct. Upon a conviction of an offense under this subsection, the prosecutor shall certify the conviction to the appropriate licensing board in the Department of State which shall suspend or revoke the health care provider's license.

(c) A lawyer or health care provider may not compensate or give anything of value to a person for providing names, addresses, telephone numbers or other identifying information of individuals seeking or receiving medical or rehabilitative care for accident, sickness or disease, except to the extent a referral and receipt of compensation is permitted under applicable professional rules of conduct. A person may not knowingly transmit such referral information to a lawyer or health care professional for the purpose of receiving compensation or anything of value. Attempts to circumvent this subsection through use of any other person, including, but not limited to, employes, agents or servants, shall also be prohibited.

Sec 1104 If an insurance claim is made by means of computer billing tapes or other electronic means, it shall be a rebuttable presumption that the person knowingly made the claim if the person has advised the insurer in writing that claims will be submitted by use of computer billing tapes or other electronic means.

Sec 1105 (a) A person who violates section 1102 shall be guilty of a felony of the third degree and, upon conviction thereof, shall be sentenced to pay a fine of not more than fifty thousand dollars ($50,000) or double the value of the fraud or to undergo imprisonment for a period of not more than seven years, or both.

(b) A person who violates section 1103 shall be guilty of a misdemeanor of the first degree and, upon conviction thereof, shall be sentenced to pay a fine of not more than twenty thousand dollars ($20,000) or double the amount of the fraud, or both.

(c) A health care provider or lawyer who is guilty of an offense under section 1102 while acting on behalf of others shall be subject to disciplinary action, including suspension or revocation of a license or certificate or recommendation for suspension or disbarment to the Supreme Court, on the same basis as a health care provider or lawyer who is guilty of an offense under section 1103.

Sec 1106 The court may, in addition to any other sentence authorized by law, sentence a person convicted of violating this section to make restitution under 18 Pa.C.S § 1106 (relating to restitution for injuries to person or property).

Sec 1107 An insurer and any agent, servant or employe thereof acting in the course and scope of his employment shall be immune from civil or criminal liability arising from the supply or release of written or oral information to any entity duly authorized to receive such information by Federal or State law or by Insurance Department regulations only if the information is supplied to the agency in connection with an allegation of fraudulent conduct on the part of any person relating to a violation of this article and the insurer, agent, servant or employe has reason to believe that the information supplied is related to the allegation of fraud.

Sec 1108 Nothing in this article shall be construed to prohibit any conduct by an attorney or law firm which is expressly permitted by the Rules of Professional Conduct of the Supreme Court, by statute or by regulation, or prohibit any conduct by a health care provider which is expressly permitted by law or regulation.

Sec 1109 (a) The district attorneys of the several counties shall have authority to investigate and to institute criminal proceedings for any violation of this article.

(b) In addition to the authority conferred upon the Attorney General by the act of October 15, 1980 (P.L. 950, No. 164), known as the "Commonwealth Attorneys Act," the Attorney General shall have the authority to investigate and to institute criminal proceedings for any violation of this section or any series of such violations involving more than one county of this Commonwealth or involving any county of this Commonwealth and another state. No person charged with a violation of this article by the Attorney General shall have standing to challenge the authority of the Attorney General to investigate or prosecute the case, and, if any such challenge is made, the challenge shall be dismissed and no relief shall be available in the courts of the Commonwealth to the person making the challenge.

(c) Nothing in this act shall prevent prosecution under 18 Pa.C.S. § 4117 (relating to insurance fraud) or any other provision of law.

Sec 1110 Nothing contained in this article shall be construed to limit the regulatory or investigative authority of any department or agency of the Commonwealth whose functions might relate to persons, enterprises or matters falling within the scope of this article.

Sec 1111 (a) A person found by a court of competent jurisdiction, pursuant to a claim initiated by a prosecuting authority, to have violated any provision of section 1102 shall be subject to civil penalties of not more than five thousand dollars ($5,000) for the first violation, ten thousand dollars ($10,000) for the second violation and fifteen thousand dollars ($15,000) for each subsequent violation. The penalty shall be paid to the prosecuting authority to be used to defray the operating expenses of investigating and prosecuting violations of this article. The court may also award court costs and reasonable attorney fees to the prosecuting authority.

(b) If a prosecuting authority has probable cause to believe that a person has violated this section, nothing in this clause shall be construed to prohibit the prosecuting authority and the person from entering into a written agreement in which that person does not admit or deny the charges but consents to payment of the civil penalty. A consent agreement may not be used in a subsequent civil or criminal proceeding, but notification thereof shall be made to the licensing authority if the person is licensed by a licensing authority of the Commonwealth so that the licensing authority may take appropriate administrative action.

(c) All fines and penalties imposed following a conviction for a violation of this article shall be collected in the manner provided by law and shall be paid in the following manner:

(1) If the prosecutor is a district attorney, the fines and penalties shall be paid into the operating fund of the county in which the district attorney is elected.

(2) If the prosecutor is the Attorney General, the fines and penalties shall be paid into the State Treasury and appropriated to the Office of Attorney General.

Sec 1112 A prosecution for an offense under this act must be commenced within five years after commission of the offense.

ARTICLE XII
Fraud Enforcement

Sec 1201 The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Antifraud plan" means the insurance antifraud plan required to be filed and maintained pursuant to this article.

"Commissioner" means the Insurance Commissioner of the Commonwealth.

"Department" means the Insurance Department of the Commonwealth.

Sec 1202 (a) The department is authorized to refer to the appropriate law enforcement official violations of Article XI if the department has reason to believe that a person has engaged in or is engaging in an act or practice that violates Article XI.

(b) The department shall furnish all papers, documents, reports, complaints or other facts or evidence to any police, sheriff or other law enforcement agency or governmental entity duly authorized to receive such information, when so requested, and shall assist and cooperate with those agencies.

Sec 1203 A workers' compensation insurer shall institute and maintain an insurance antifraud plan.

Sec 1204 All workers' compensation insurers shall annually provide to the department a summary report on actions taken under an antifraud plan to prevent and combat insurance fraud, including, but not limited to, measures taken to protect and ensure the integrity of electronic data processing-generated data and manually compiled data, statistical data on the amount of resources committed to combating fraud and the amount of fraud identified and recovered during the reporting period.

Sec 1205 (a) Every workers' compensation insurer and its employes, agents and brokers are authorized to refer to the appropriate law enforcement official violations of Article XI if the insurer, employe, agent or broker has reason to believe that a person has engaged in or is engaging in an act or practice that violates Article XI.

(b) The insurer, its employes, agents and brokers, shall furnish all papers, documents, reports, complaints or other facts or evidence to any police, sheriff or other law enforcement agency or governmental entity duly authorized to receive such information, when so requested, and shall assist and cooperate with those agencies.

ARTICLE XIII
Small Business Advocate

Sec 1301 As used in this article:

"Department" means the Insurance Department of the Commonwealth.

Sec 1302 In addition to his powers and duties under the act of December 21, 1988 (P.L. 1871. No. 181), known as the "Small Business Advocate Act," the small business advocate shall have standing to represent the interest of employers as a party in proceedings before the department or any court involving filings by rating organizations and insurers pursuant to Article VII.

Sec 1303 (a) In addition to any other assessment authorized by section 446, an additional annual assessment shall be made on insurers, including the State Workmen's Insurance Fund but not including self-insureds, as a percentage of the total compensation paid for the purpose of funding the operations of the Office of Small Business Advocate pursuant to this act. Assessments under this section shall be made by the department and deposited into the Workmen's Compensation Administration Fund in a restricted account to be used by the Office of Small Business Advocate. The total amount assessed shall be the amount of the budget approved annually by the General Assembly for the operations of the Office of Small Business Advocate pursuant to this act.

(b) The total moneys assessed under the act of December 28, 1994 (P.L. 1414, No. 166), known as the Insurance Fraud Prevention Act, shall be permitted to be utilized by the Section of Insurance Fraud, within the Office of Attorney General, for prosecution and investigation of crimes arising under section 1102 and 18 Pa.C.S. § 4117 (relating to insurance fraud), as well as other grants by the Insurance Fraud Prevention Authority.

Sec 1304 Nothing contained in this article shall in any way limit the right of any person to bring a proceeding before either the department or a court.

ARTICLE XIV
Workers' Compensation Judges

Sec 1401 (a) There is created within the department an office to be known as the Office of Adjudication.

(b) The secretary shall appoint as many qualified and competent workers' compensation judges as necessary to conduct matters under this act.

(c) The secretary shall set normal working hours for workers' compensation judges. During those hours, workers' compensation judges shall devote full time to their official duties and shall perform no work inconsistent with their duties as workers' compensation judges. Workers' compensation judges shall not engage in any unapproved activities during normal working hours.

(d) Workers' compensation judges shall be afforded employment security as provided by the act of August 5, 1941 (P.L.752, No.286), known as the "Civil Service Act."

(e) Compensation for workers' compensation judges shall be established by the Executive Board.

(f) The secretary shall develop and require all workers' compensation judges to complete a course of training and instruction in the duties of their respective offices and pass an examination prior to assuming office. The course of training and instruction shall not exceed four weeks in duration and shall consist of a minimum of forty hours of class instruction in medicine and law.

(g) The secretary shall develop a continuing professional development plan for workers' compensation judges which shall require the annual completion of twenty hours of approved continuing professional development courses.

(h) The secretary may adopt additional rules to establish standards and procedures for the evaluation, training, promotion and discipline of workers' compensation judges.

Sec 1402 (a) The secretary shall appoint a director of adjudication, who:

(1) must meet the qualifications under section 1403;

(2) shall serve at the pleasure of the secretary; and

(3) shall report directly to the secretary or a designee.

(b) The position of director of adjudication shall be part of the unclassified service, as provided for by the act of August 5, 1941 (P.L.752, No.286), known as the "Civil Service Act."

(c) The director of adjudication shall be responsible for assigning a workers' compensation judge to every matter which may require the utilization of a workers' compensation judge. The director of adjudication shall also have other responsibilities as the secretary may prescribe.

(d) The director of adjudication shall receive remuneration above that of any other workers' compensation judge.

Sec 1403 Workers' compensation judges shall be management level employes and must meet the following minimum requirements:

(1) Be an attorney in good standing before the Supreme Court.

(2) Have five years of workers' compensation practice before administrative agencies or equivalent experience.

(3) Complete the course of training and instruction and pass the examination under section 1401(f).

(4) Meet the annual continuing professional development requirement established by the secretary under section 1401(g).

(5) Conform to other requirements as established by the secretary.

Sec 1404 (a) A workers' compensation judge shall conform to the following code of ethics:

(1) Avoid impropriety and the appearance of impropriety in all activities.

(2) Perform duties impartially and diligently.

(3) Avoid ex parte communications in any contested, on-the-record matter pending before the department.

(4) Abstain from expressing publicly, except in administrative disposition or adjudication, personal views on the merits of an adjudication pending before the department and require similar abstention on the part of department personnel subject to the workers' compensation judge's direction and control.

(5) Require staff and personnel subject to the workers' compensation judge's direction and control to observe the standards of fidelity and diligence that apply to a workers' compensation judge.

(6) Initiate appropriate disciplinary measures against department personnel subject to the workers' compensation judge's direction and control for unethical conduct.

(7) Disqualify himself from proceedings in which impartiality may be reasonably questioned.

(8) Keep informed about the personal and fiduciary interests of himself and his immediate family.

(9) Regulate outside activities to minimize the risk of conflict with official duties. A workers' compensation judge may speak, write or lecture, and reimbursed expenses, honorariums, royalties or other money received in connection therewith shall be disclosed annually. A disclosure statement shall be filed with the secretary and the State Ethics Commission and shall be open to inspection by the public during the normal business hours of the department and the commission during the tenure of the workers' compensation judge.

(10) Refrain from direct or indirect solicitation of funds for political, educational, religious, charitable, fraternal or civil purposes: Provided, however, That a workers' compensation judge may be an officer, a director or a trustee of such organizations.

(11) Refrain from financial or business dealings which would tend to reflect adversely on impartiality. A workers' compensation judge may hold and manage investments which are not incompatible with the duties of office.

(12) Conform to additional requirements as the secretary may prescribe.

(13) Uphold the integrity and independence of the workers' compensation system.

(b) Any workers' compensation judge who violates the provisions of clause (a) shall be removed from office in accordance with the provisions of the act of August 5, 1941 (P.L.752, No.286), known as the "Civil Service Act."

Sec 1405 The secretary shall determine the appropriate staff, facilities and administrative support so that the duties of workers' compensation judges may be performed.

Sec 1406 Individuals who are currently serving as workers' compensation judges shall continue to serve as workers' compensation judges, subject to sections 1401(c) and 1404.

ARTICLE XV
State Workers' Insurance Fund

Sec 1501 As used in this article:

"Advisory council" means the Advisory Council to the State Workers' Insurance Board.

"Board" means the State Workers' Insurance Board.

"Bureau" means the Bureau of Workers' Compensation of the Department of Labor and Industry.

"Downward deviation" means the extent to which the State Workers' Insurance Board provides deviations under section 654 of the act of May 17, 1921 (P.L. 682, No. 284), known as "The Insurance Company Law of 1921," in the premiums charged to State Workers' Insurance Fund subscribers below the otherwise applicable premium rates approved by the Insurance Commissioner for use by the board.

"Fund" means the State Workers' Insurance Fund.

"Reserve funds" means the Sunny Day Fund and the Tax Stabilization Reserve Fund, created by the act of July 1, 1985 (P.L. 120, No. 32), entitled "An act creating a special fund in the Treasury Department for use in attracting major industry into this Commonwealth; establishing a procedure for the appropriation and use of moneys in the fund; establishing the Tax Stabilization Reserve Fund; and providing for expenditures from such account."

"Safely distributable" means amounts which are distributable without jeopardizing the ability of the State Workers' Insurance Fund to satisfy its present and future legal obligations to subscribers.

"Surplus" means the amount in the State Workers' Insurance Fund in excess of the fund's liabilities under this act.

"Taxes" means the amount that would be payable as taxes upon receipt of premiums by a private insurance company under section 902 of the act of March 4, 1971 (P.L. 6, No. 2), known as the "Tax Reform Code of 1971," and the amount that would be payable as Federal income tax by a private insurance company under section 831 of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 831), or any amendments to either statute subsequently enacted. For purposes of computing Federal capital gains or losses (for such hypothetical Federal income tax under section 831 of the Internal Revenue Code of 1986) for periods after June 30, 1990, the basis of State Workers' Insurance Fund assets will be the fair market value on June 30, 1990.

Sec 1502 The State Workers' Insurance Board is hereby continued, consisting of the Secretary of Labor and Industry, the Insurance Commissioner and the State Treasurer.

Sec 1503 (a) The Advisory Council to the State Workers' Insurance Board is hereby continued.

(b) The advisory council shall be appointed by the board and shall be composed of five members, with one member representing each of the following:

(1) The Pennsylvania Chamber of Business and Industry or its successor organization.

(2) The American Federation of Labor-Congress of Industrial Organizations (AFL-CIO) or its successor organization.

(3) Insureds of the fund with premiums of five thousand dollars ($5,000) or less annually.

(4) Insureds of the fund with premiums of more than five thousand dollars ($5,000) annually.

(5) The board.

The member of the advisory council representing the board shall serve as chair of the advisory council. The member representing the Pennsylvania Chamber of Business and Industry shall be selected from a list of persons recommended by that organization or its successor. The member representing the AFL-CIO shall be selected from a list of persons recommended by that organization or its successor.

(c) Each member shall serve a term of two (2) years, commencing on January 1 of each odd-numbered year, and shall serve until the board appoints a successor. The board shall make initial appointments within sixty (60) days of the effective date of this section.

(d) Members of the advisory council shall receive no compensation; each member, however, shall be entitled to be reimbursed for reasonable and legitimate expenses incurred in the performance of his duties.

(e) The advisory council shall have the following powers and duties:

(1) Commission, in its discretion, an actuarial study of the fund no more than once a year.

(2) Review any actuarial studies of the fund commissioned by the board under section 1511(b).

(3) Request and receive from the board copies of or access to audits of the fund.

(4) Recommend to the board annually the amount of surplus in the fund, if any, which is safely distributable.

(5) Recommend to the board annually the form in which any safely distributable surplus should be distributed if the board has determined that a safely distributable surplus exists.

(6) Request assistance from the board as may be necessary to fulfill the advisory council's statutory obligations under this section. The advisory council shall make no recommendation to the board unless that recommendation reflects the votes of a majority of advisory council members. Should a majority of the advisory council's members vote to commission an actuarial study of the fund independent of the board's actuarial study, the board shall pay for the reasonable and customary expense associated with the preparation of such a study.

Sec 1504 Certain sums to be paid by employers, as provided in this article, are hereby continued as a fund, hereafter to be known as the State Workers' Insurance Fund, for the purpose of insuring such employers against liability under Article III of this act and of assuring the payment of the compensation therein provided and for the purpose of insuring such employers against liability under the Federal Coal Mine Health and Safety Act of 1969 (Public Law 91-173, 30 U.S.C. § 801 et seq.) and the Longshore and Harbor Workers' Compensation Act (44 Stat. 1424, 33 U.S.C. § 901 et seq.) and of assuring the payment of benefits therein provided and further for the purpose of insuring such employers against liability for all sums such employer shall become legally obligated to pay any employe of his as damages because of bodily injury by accident or disease, including death at any time resulting therefrom, sustained by such employe arising out of and in the course of his employment. Such fund shall be administered by the board, without liability on the part of the Commonwealth, except as provided in this article, beyond the amount thereof, and shall be applied to the payment of such compensation.

Sec 1505 The State Treasurer shall be the custodian of the fund, and all disbursements therefrom shall be paid by him by check, upon requisition of the secretary. It shall not be necessary for the State Treasurer to audit the accounts which the requisition of the secretary calls upon him to pay and for making payments according to the requisition of the secretary without audit the State Treasurer shall not be under any liability whatsoever. The State Treasurer may deposit any portion of the fund not needed for immediate use as other State funds are lawfully deposited, and the interest thereon shall be collected by him and placed to the credit of the fund.

Sec 1506 On or before October 1 in each year, the board shall prepare and publish a schedule of premiums or rates of insurance for employers under Article III; employers who want insurance against liability under the Federal Coal Mine Health and Safety Act of 1969 (Public Law 91-173, 30 U.S.C. § 801 et seq.); employers who want insurance against liability under the Longshore and Harbor Workers' Compensation Act (44 Stat. 1424, 33 U.S.C. § 901 et seq.); and employers who want insurance against liability for all sums such employer shall become legally obligated to pay any employe of his as damages because of bodily injury by accident or disease, including death at any time resulting therefrom, sustained by such employe arising out of and in the course of his employment. This schedule shall be printed and distributed free of charge to employers. An employer may pay to the fund the amount of the premium appropriate to his business or domestic affairs and, upon payment thereof, shall thereafter be considered a subscriber to the fund and shall be insured as provided in this article for the year for which the premium is paid. This insurance shall cover all payments becoming due in any year because of accidents occurring during the year for which the premium is paid.

Sec 1507 The board shall determine the amount of premiums which the subscribers to the fund shall pay and shall fix the premiums for insurance in accordance with the nature of their business and of the various employments of their employes, and the probable risk of injury to their employes. They shall fix the premiums at such an amount as shall be adequate to enable them to pay all sums which may become due and payable to the employes of such subscribers, under the provisions of Article III of this act, under the provisions of the Longshore and Harbor Workers' Compensation Act (44 Stat. 1424, 33 U.S.C. § 901 et seq.) and under the provisions of the Federal Coal Mine Health and Safety Act of 1969 (Public Law 91-173, 30 U.S.C. § 801 et seq.); and, by reason of a subscriber's liability for all sums, such subscriber shall become legally obligated to pay any employe of his as damages because of bodily injury by accident or disease, including death at any time resulting therefrom, sustained by such employe arising out of and in the course of his employment, and to create and maintain the surplus provided in section 1509 and to provide an adequate reserve sufficient to carry all policies and claims to maturity. In fixing the premiums payable by any subscriber, the board may take into account the condition of the plant, workroom, shop, farm, mine, quarry, operation and all other property or premises of such subscriber, in respect to the safety of those employed therein, as shown by the report of any inspector appointed by the board or by the department. The board may, from time to time, change the amount of premiums payable by any of the subscribers as circumstances may require and the condition of the plant, workroom, shop, farm, mine, quarry, operation or other property or premises of such subscribers, in respect to the safety of their employes, may justify. The board may increase the premiums of any subscriber neglecting to provide safety devices required by law or disobeying the rules or regulations made by the board under section 1515. The insurance of any subscriber shall not be effective until he shall have paid in full the premium so fixed and determined.

Sec 1508 The board shall file with the bureau a notice setting forth the names and places of business of those employers who from time to time shall become subscribers to the fund.

Sec 1509 The board shall set aside five per centum of all premiums collected for the creation of a surplus until this surplus shall amount to one hundred thousand dollars ($100,000), and thereafter they may set apart such percentage, not exceeding five per centum, as in their discretion they may determine to be necessary to maintain such surplus sufficiently large to cover the catastrophe hazard of all the subscribers to the fund and to guarantee the solvency of the fund.

Sec 1510 The board shall divide the subscribers into groups, in accordance with the nature of the business of such subscribers and the probable risk of injury therein, and they shall fix all premiums for each group in accordance with the experience thereof. Where the employes in any business are engaged in various employments in which the risk of injury is substantially different, the board may subdivide the employments into classes and shall fix the premium for each in accordance with the probable risk of injury therein.

Sec 1511 (a) The moneys in the fund are hereby made available and shall be paid:

(1) For the expenses of administering the fund, including the purchase through the Department of General Services of surety bonds for such officers or employes of the board as may be required to furnish them, supplies, materials, motor vehicles, workers' compensation insurance covering the officers and employes of the board, and liability insurance covering vehicles purchased out of moneys of the fund and operated by the officers and employes of the board. In the event that the use of motor vehicles is required only temporarily, then such moneys in the fund are available for the payment to the Department of General Services for the use of such motor vehicles on a mileage basis, at such amount per mile as the Department of General Services, with the approval of the Governor, shall determine.

(2) For payment to the Treasury Department of the cost of making disbursements out of the fund, on behalf of the board, at such amounts as the Treasury Department, with the approval of the Executive Board, shall determine.

(3) For payment to the Department of General Services for space occupied in government buildings and for water, light, heat, power, telephone and other services utilized and consumed by the board, at such amounts as the Department of General Services, with the approval of the Executive Board, shall determine.

(4) For payment to the General Fund in amounts which would have been paid in taxes had the fund been subject to taxes for the period beginning on July 1, 1990, and thereafter. These payments shall be due annually, shall be calculated on a fiscal year basis and shall be paid in equal quarterly installments of the board's estimate of taxes for a fiscal year. Quarterly installments shall be paid after the end of each quarter, and the fourth quarterly installment for each fiscal year shall be adjusted upward or downward as necessary to pay in full the amount due.

(b) The board shall retain the services of a certified actuary who shall be responsible for conducting an annual independent actuarial study of the fund. The purpose of the study shall be to assist the board in determining whether the moneys in the fund exceed the fund's liabilities and, if so, whether any portion of that surplus is safely distributable. Payment for the annual actuarial study shall be considered to be an expense of administering the fund. The precise nature and scope of the study shall be determined by the board. The study shall be made available to the advisory council under clause (e) of section 1503. All persons charged with the administration or management of the fund shall provide the actuary or his agents with the means, facilities and opportunity to examine all books, records and papers pertaining to the fund.

(c) The board shall keep an accurate account of the money paid in premiums by the subscribers, the income derived from investment of premiums and the disbursement of amounts paid under clause (a). At the expiration of each calendar year after 1990 and upon review of the independent actuarial study conducted under clause (b) and advisory council recommendations, if any, the board shall determine if there is a surplus remaining in the fund after deductions are made for disbursements identified in clause (a), the unearned premiums on undetermined risks, the percentage of premiums paid or payable to create or maintain the surplus provided in section 1509 and the setting aside of an adequate reserve. If a surplus exists in the fund and if after reviewing the recommendations of the

advisory council, if any, the board determines that a portion of the surplus is safely distributable, the board shall distribute the safely distributable surplus as follows:

(1) An amount up to the amount of any downward deviation that had been granted to subscribers at the start of that calendar year may be transferred to the reserve funds, as appropriated by the General Assembly.

(2) At least one-half of any safely distributable surplus not transferred to the reserve funds under paragraph (1) shall be available for appropriation by the General Assembly for distribution to subscribers or former subscribers who paid premiums in that calendar year in proportion to the premiums each such subscriber or former subscriber paid in that year.

(3) Any portion of the remaining safely distributable surplus up to the amount distributed to subscribers or former subscribers pursuant to paragraph (2) may be transferred to the reserve funds, as appropriated by the General Assembly.

Any amount distributed to subscribers pursuant to paragraph (2) shall be distributed among the subscribers, in proportion to the premiums paid by them; and the proportionate share of such subscribers as shall remain subscribers to the fund shall be credited to the installment of premiums next due by them, and the proportionate share of such subscribers as shall have ceased to be subscribers in the fund shall be refunded to them, out of the fund.

(a) No appropriation under clause (c) shall impair the actuarial soundness of the fund.

Sec 1512 The board may invest any of the surplus or reserve belonging to the fund in such securities and investments as are authorized for investment by savings banks. All such securities or evidences of indebtedness shall be placed in the hands of the State Treasurer who shall be the custodian thereof. He shall collect the principal and interest thereof when due and pay the same into the fund. The State Treasurer shall pay for all such securities or evidences of indebtedness by check issued upon requisition of the secretary. All such payments shall be made only upon delivery of such securities or evidences of indebtedness to the State Treasurer. To all requisitions calling upon the State Treasurer to pay for any securities or evidences of indebtedness there shall be attached a certified copy of the resolution of the board authorizing the investment. The board may, upon like resolution, sell any of such securities.

Sec 1513 The board shall have the power to make all contracts necessary for supplying medical, hospital, and surgical services, as provided in clause (e) of section 306.

Sec 1514 The board shall have the power to reinsure any risk or join any insurance pool which it may deem necessary.

Sec 1515 (a) The board shall be entitled to inspect the plant, workroom, shop, farm, mine, quarry, operation and all other property or premises of any subscriber and shall be entitled to examine from time to time the books, records and payrolls of any subscriber or intending subscriber for the purpose of determining the amount of the premium payable to such subscriber or intending subscriber. The board shall have the power to appoint those inspectors and auditors as may be necessary to carry out the powers given in this section. The board may, with the consent of the department and commissioner, cause this inspection and examination to be made by the inspectors of the department and the auditors of the Insurance Department. These inspectors and auditors shall have free access to all such premises, books, records and payrolls during the regular working and office hours.

(b) The board shall make reasonable rules and regulations for the prevention of injuries upon the premises of the subscribers, and they may refuse to insure or may terminate the insurance of any

subscriber who refuses to permit such examinations or disregards such rules or regulations and may forfeit one-half of the unearned premiums previously paid by him.

Sec 1516 (a) Any employer subject to Article III and who shall desire to become a subscriber to the fund for the purpose of insuring his liability to his employes; and any employer who wants insurance under the Longshore and Harbor Workers' Compensation Act (44 Stat. 1424, 33 U.S.C. § 901 et seq.); and any employer who wants insurance under the Federal Coal Mine Health and Safety Act of 1969 (Public Law 91-173, 30 U.S.C. § 801 et seq.) and who shall desire to become a subscriber to the fund for the purpose of insuring his liability to his employes; and any employer who shall desire to become a subscriber to the fund for the purpose of insuring therein his liability for all sums the employer shall become legally obligated to pay any employe of his as damages because of bodily injury by accident or disease, including death at any time resulting therefrom, sustained by such employe arising out of and in the course of his employment, shall make a written application for such insurance to the board. In the application, the applicant shall state:

(1) The nature of the business or domestic affairs in which insurance is desired.

(2) The average number of employes expected to be employed in such business during the year for which insurance is sought and the average number of employes, if any, engaged in such business during the year previous to the application.

(3) The approximate money wages expected to be paid during the year for which insurance is sought and the money wages paid to such employes during the preceding year.

(4) The place where the business is to be transacted.

(5) The place where the employer's payroll and books of accounts are kept and where the employes are customarily paid.

(6) Such other facts and information as the board shall require.

(b) When the employments are subdivided into classes, as provided in section 1510, the applicant shall state:

(1) The number of employes of each class expected to be employed or previously employed.

(2) The approximate money wages expected to be paid or previously paid, as aforesaid, to employes of each class for which insurance is sought.

(c) Upon submission of the application, the board shall make such investigations as it may deem necessary and, within thirty (30) days after the application, shall issue a certificate showing the classification or group in which such applicant is entitled to be placed and the amount of premium payable by such applicant for the year for which insurance is sought. No insurance shall be issued for a longer period than a single year.

Sec 1517 All premiums shall be payable to the State Treasurer who shall issue an appropriate receipt therefor, and such receipt, together with the certificate of the board specified in section 1516, shall be the evidence that the applicant has become a subscriber to the fund and is insured therein.

Sec 1518 Each subscriber to the fund shall, within one (1) month after his subscription has terminated, furnish a written statement to the board setting forth the maximum average and minimum number of employes insured in the fund that such subscriber had employed during the preceding year, and the actual amount of the money payroll of such employes for such year. When the board has subdivided the employments in any group into

classes, as provided in section 1510, the subscriber shall state the number and actual amounts of the money payroll of such employes of each of such classes. Within thirty (30) days, the board shall state the account of each subscriber for that year, based on the facts thus proven, and shall render a copy of this statement to the subscriber. If the amount of the premium theretofore paid by a subscriber shall exceed the amount due according to such stated account, then the excess shall be forthwith refunded to the subscriber by payment out of the fund. If the amount shown by the statement exceeds the amount of the premium theretofore paid by the subscriber, the excess shall be forthwith due and payable by the subscriber into the fund, and until paid shall be a lien, as State taxes are a lien, upon the real and personal property of the subscriber and, if unpaid, shall be collectible as State taxes are now collectible, with interest at the rate of twelve per centum per annum commencing thirty (30) days after service of the copy of the account, which service shall be by registered mail.

Sec 1519 Any person who shall knowingly furnish or make any false certificate, application or statement required in this article shall be guilty of a misdemeanor. Any subscriber who shall, after notice from the board, neglect or refuse to file the statement described in section 1518 within ten (10) days after such notice shall be liable to pay to the fund a penalty of ten dollars ($10) for each day that such neglect or refusal shall continue, to be recovered at the suit of the fund.

Sec 1520 (a) Any subscriber to the fund who shall, within seven (7) days after knowledge or notice of an accident to an employe in the course of his employment as required by section 311, have filed with the board a true statement of such knowledge or a true copy of the notice shall be discharged from all liability for the payment of compensation for the personal injury or death of such employe by such accident; and all such compensation due therefor under Article III shall be paid out of the fund. The report of the accident required by the act of July 19, 1913 (P.L. 843, No. 408), referred to as the Employee Injury Reporting Law, shall be sufficient compliance with this section if that report is made within seven (7) days of the injury and shall state that the employer making the report is a subscriber to the fund.

(b) Nothing in this section shall discharge any employer from the duty of supplying the medical and surgical services, medicine, and supplies required by section 306. Any subscriber who has supplied such services, medicines and supplies shall be reimbursed therefor from the fund. Any subscriber to the fund who, within seven (7) days after knowledge of an accident to any employe arising out of and in the course of his employment and such accident comes within the purview of the Federal Coal Mine Health and Safety Act of 1969 (Public Law 91-173, 30 U.S.C. § 801 et seq.) or of the Longshore and Harbor Workers' Compensation Act (44 Stat. 1424, 33 U.S.C. § 901 et seq.), has filed with the board a true statement of such knowledge shall be discharged from all liability for the payment of benefits for the personal injury or death of such employe by such accident, and all such benefits due therefor under provisions of the Longshore and Harbor Workers' Compensation Act or the Federal Coal Mine Health and Safety Act of 1969 shall be paid out of the fund. Any subscriber to the fund who shall, within seven (7) days after knowledge of an accident to an employe arising out of and in the course of his employment, have filed with the board a true statement of such knowledge shall be discharged from all liability for all sums such subscriber shall become legally obligated to pay any employe of his as damages because of bodily injury by accident or disease, including death at any time resulting therefrom, sustained by such employe arising out of and in the course of his employment, and all such sums shall be paid out of the fund.

Sec 1521 In every case where a claim is made against the fund, the fund shall be entitled to every defense against such claim that would have been open to the employer and shall be subrogated to every right of the employer arising out of such accident against the employe, the dependents and against third persons. The fund may, in the name of the State Workers' Insurance Fund, sue or be sued to enforce any right given against or to any subscriber or other person under this act or the Longshore and Harbor Workers' Compensation Act (44 Stat. 1424, 33 U.S.C. § 901 et seq.) or the Federal Coal Mine Health and Safety Act of 1969 (Public Law 91-173, 30 U.S.C. § 801 et seq.) and employers who want insurance against liability for all sums or under circumstances where an employer becomes legally obligated to pay any

employe for damages because of bodily injury by accident or disease, including death at any time resulting therefrom, sustained by such employe arising out of and in the course of his employment; proceedings provided in Article IV may be instituted by or against the fund to enforce, before the Workers' Compensation Appeal Board or any workers' compensation judge thereof, the rights given to or against the fund by this act.

Sec 1522 Upon receipt of a notice or statement of knowledge of an accident to an employe of a subscriber occurring in the course of his employment, the board shall, if it deems necessary, cause an investigation to be made by an inspector appointed by it or an inspector of the department.

Sec 1523 (a) The board is hereby empowered to execute the agreements provided in this act and to promulgate such regulations as they may deem necessary for this purpose. When any such agreement has been approved by the department, the same shall be properly filed and docketed and the board shall from time to time until such agreement shall be modified or terminated as provided in this act, pay the sums therein agreed upon. All such payments shall be made by check of the State Treasurer issued upon requisition of the secretary. Every such check shall be mailed to the person or persons entitled thereto under such agreement. When any award is made by the Workers' Compensation Appeal Board or by a workers' compensation judge in any proceedings brought by an employe of a subscriber or the dependents of such employe against the fund, this award shall be filed and docketed, and the board shall from time to time until such award is modified, reversed or terminated pay the sums therein lawfully awarded against the fund. All such payments shall be made by check of the State Treasurer issued upon requisition of the secretary, and every such check shall be mailed to the person or persons entitled thereto under the award.

(b) When any proceedings brought by an employe of a subscriber or the dependents of such employe against the fund for benefits payable under the Longshore and Harbor Workers' Compensation Act (44 Stat. 1424, 33 U.S.C. § 901 et seq.) or the Federal Coal Mine Health and Safety Act of 1969 (Public Law 91-173, 30 U.S.C. § 801 et seq.), such proceedings shall be filed and docketed; the board shall from time to time until such benefits are modified, reversed, or terminated pay such benefit sums for which the fund is legally responsible. All such payments shall be made by check of the State Treasurer issued upon requisition of the secretary, and every such check shall be mailed to the person or persons entitled thereto.

(c) When any proceedings brought by an employe of a subscriber or the dependents of such employe against the fund for sums such subscriber shall become legally obligated to pay any employe of his as damages because of bodily injury by accident or disease, including death at any time resulting therefrom, sustained by such employe arising out of and in the course of his employment, such proceedings shall be filed and docketed, and the board shall from time to time until such damage sums are modified, reversed or terminated pay such damage sums for which the fund is legally responsible. All such payments shall be made by check the State Treasurer issued upon requisition of the secretary, and every such check shall be mailed to the person or persons entitled thereto.

Sec 1524 All salaries, wages, fees or other compensation of physicians, attorneys, investigators, assistants and other employes necessary for the proper administration of the fund and the proper conduct of the work of the board shall be paid out of the fund. All payments to employes, dependents of deceased employes, physicians, attorneys, investigators, assistants and others entitled to be paid out of the fund shall be made by the State Treasurer upon requisition of the secretary.

Sec 1525 Information acquired by the fund, its officers and employes from employers, employes or insurance corporations or associations shall not be open to public inspection.

ARTICLE XVI
Uninsured Employers Guaranty Fund

Sec 1601 The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Compensation." Benefits paid pursuant to sections 306 and 307.

"Employer." Any employer as defined in section 103. The term does not include a person that qualifies as a self-insured employer under section 305.

"Fund." The Uninsured Employers Guaranty Fund established in section 1602. The fund shall not be considered an insurer and shall not be subject to penalties, unreasonable contest fees or any reporting and liability requirements under section 440.

"Policyholder." A holder of a workers' compensation policy issued by the State Workers' Insurance Fund, or an insurer that is a domestic, foreign or alien mutual association or stock company writing workers' compensation insurance on risks which would be covered by this act.

"Secretary." The Secretary of Labor and Industry of the Commonwealth.

Sec 1602 (a) Establishment.—

(1) There is established a special fund to be known as the Uninsured Employers Guaranty Fund.

(2) The fund shall be maintained as a separate fund in the State Treasury subject to the procedures and provisions set forth in this article.

(b) Source. — The sources of the fund are:

(1) Assessments provided for under section 1607.

(2) Reimbursements or restitution.

(3) Interest on money in the fund.

(c) Use. — The administrator shall establish and maintain the fund for the exclusive purpose of paying to any claimant or his dependents workers' compensation benefits due and payable under this act and the act of June 21, 1939 (P.L. 566, No. 284), known as The Pennsylvania Occupational Disease Act, and any costs specifically associated therewith where the employer liable for the payments failed to insure or self-insure its workers' compensation liability under section 305 at the time the injuries took place.

(d) Administration. — The secretary shall be the administrator of the fund and shall have the power to collect money for and disburse money from the fund.

(e) Status.— The fund shall have all of the same rights, duties, responsibilities and obligations as an insurer.

Sec 1603 (a) Scope.— This section shall apply to claims for an injury or a death which occurs on or after the effective date of this article.

(b) Time.— An injured worker shall notify the fund within 45 days after the worker knew that the employer was uninsured. The department shall have adequate time to monitor the claim and shall

determine the obligations of the employer. No compensation shall be paid from the fund until notice is given and the department determines that the employer failed to voluntarily accept and pay the claim or subsequently defaulted on payments of compensation. No compensation shall be due until notice is given.

(c) Process.— After notice, the fund shall process the claim in accordance with the provisions of this act.

(d) Petitions.— No claim petition may be filed against the fund until at least 21 days after notice of the claim is made to the fund.

Sec 1604 If a claim for compensation is filed under this article and the claim is not voluntarily accepted as compensable, the employee may file a claim petition naming both the employer and the fund as defendants. Failure of the uninsured employer to answer a claim petition shall not serve as an admission or otherwise bind the fund under section 416.

Sec 1605 (a) Insurance inquiry.— Within ten days of notice of a claim, the fund shall demand from the employer proof of applicable insurance coverage. Within 14 days from the date of the fund's request, the employer must provide proof of insurance. If the employer does not provide proof, there shall be rebuttable presumption of uninsurance.

(b) Reimbursement.— The department shall, on behalf of the fund, exhaust all remedies at law against the uninsured employer in order to collect the amount of a voluntary payment or award, including voluntary payment or award itself and reimbursement of costs, interest, penalties, fees under section 440 and costs of the fund's attorney, which have been paid by the fund. The fund shall also be reimbursed for costs or attorney fees which are incurred in seeking reimbursement under this subsection. The department is authorized to investigate violations of section 305 for prosecution of the uninsured employer pursuant to section 305(b) and shall pursue such prosecutions through coordination with the appropriate prosecuting authority. Any restitution obtained shall be paid to the fund.

(c) Bankruptcy.— The department has the right to appear and represent the fund as a creditor in a bankruptcy proceeding involving the uninsured employer.

(d) Liens.— If payments of any nature have been made by the fund on behalf of an uninsured employer, the fund shall file a certified proof of payment with the prothonotary of a court of common pleas, and the prothonotary shall enter the entire balance as a judgment against the employer. The judgment shall be a statutory lien against property of the employer in the manner set forth in section 308.1 of the act of December 5, 1936 (2nd Sp.Sess., 1937 P.L. 2897, No. 1), known as the Unemployment Compensation Law, and execution may issue on it. The fund has the right to update the amount of the lien as payments are made.

Sec 1606 Nothing contained in this article shall serve to abrogate the provisions of section 305(d) allowing the claimant or dependents to bring a direct suit for damages at law as provided by Article II. The fund shall be entitled to assert rights to subrogation under section 319 for recovery made from the employer or any other third party.

Sec 1607 (a) For the purpose of establishing and maintaining the fund, the sum of $1,000,000 is hereby transferred from the Administration Fund established under section 446 to the fund for operation of the fund for the period commencing on the effective date of this section through June 30, 2007. The department shall calculate the amount necessary to maintain the fund and shall assess insurers and self-insured employers as is necessary to provide an amount sufficient to pay outstanding and anticipated claims in the following year in a timely manner and to meet the costs of the department to administer the fund. The fund shall be maintained in the same manner as the Workmen's Compensation Administration

Fund under section 446 and the regulations thereunder. In no event shall any annual assessment exceed 0.1% of the total compensation paid by all insurers or self-insured employers during the previous calendar year.

(b) For the purposes of further maintaining the fund, the sum of $4,000,000 is hereby transferred to the fund from the Administration Fund established under section 446.

Sec 1608 The department may promulgate regulations for the administration and enforcement of this article.

Pennsylvania Occupational Disease Act

"THE PENNSYLVANIA OCCUPATIONAL DISEASE ACT"
Act of June 21, 1939 (P.L. 566, No. 284)
Title 77 of Purdon's Statutes

ARTICLE I
Interpretation and Definitions

Sec 101 This act shall be called and may be cited as The Pennsylvania Occupational Disease Act. It shall apply to disabilities and deaths caused by occupational disease as defined in this act, resulting from employment within this Commonwealth, irrespective of the place where the contract of hiring was made, renewed, or extended, and shall not apply to any such disabilities and deaths resulting from employment outside of the Commonwealth.

Sec 102 Wherever in this act the singular is used, the plural shall be included; and where the masculine gender is used, the feminine and neuter shall be included.

Sec 103 The term "employer," as used in this act, is declared to be synonymous with master, and to include natural persons, partnerships, joint-stock companies, corporations for profit, corporations not for profit, municipal corporations, the Commonwealth, and all governmental agencies created by it.

Sec 104 The term "employe," as used in this act, is declared to be synonymous with servant, and includes all natural persons who perform services, except agricultural services or domestic services performed in a private home, for another for a valuable consideration, exclusive of persons whose employment is casual in character and not in the regular course of the business of the employer and exclusive of persons to whom articles or materials are given out to be made up, cleaned, washed, altered, ornamented, finished or repaired, or adapted for sale, in the worker's own home, or on other premises not under the control or management of the employer. Every executive officer of a corporation elected or appointed in accordance with the charter and by-laws of the corporation, except elected officers of the Commonwealth or any of its political subdivisions, shall be an employe of the corporation.

Sec 105 The term "contractor," as used in article two, section two hundred and three, and article three, section three hundred and two (b), shall not include a contractor engaged in an independent business, other than that of supplying laborers or assistants, in which he serves persons other than the employer in whose service the disability occurs, but shall include a subcontractor to whom a principal contractor has sublet any part of the work which such principal contractor has undertaken.

Sec 106 The exercise and performance of the powers and duties of a local or other public authority shall, for the purposes of this act, be treated as the trade or business of the authority.

Sec 107 The term "department," when used in this act, shall mean the Department of Labor and Industry of this Commonwealth.

The term "board," when used in this act, shall mean The Workmen's Compensation Board of this Commonwealth.

The term "referee," when used in this act, shall mean Workmen's Compensation Referee.

Sec 108 The term "occupational disease," as used in this act, shall mean only the following diseases:

(a) Poisoning by arsenic, lead, mercury, manganese, or beryllium, their preparations or compounds, in any occupation involving direct contact with, handling thereof, or exposure thereto.

(b) Poisoning by phosphorus, its preparations or compounds, in any occupation involving direct contact with, handling thereof, or exposure thereto.

(c) Poisoning by methanol, carbon bisulphide, carbon monoxide, hydro carbon distillates (naphthas and others), or halogenated hydro carbons, or any preparations containing these chemicals or any of them, in any occupation involving direct contact with, handling thereof, or exposure thereto.

(d) Poisoning by benzol, or by nitro, amido, or amino derivatives of benzol (dinitro-benzol, aniline, and others), or their preparations or compounds, in any occupation involving direct contact with, handling thereof, or exposure thereto.

(e) Caisson disease (compressed air illness) resulting from engaging in any occupation carried on in compressed air.

(f) Radium poisoning or disability, due to radioactive properties of substances or to Roentgen-ray (X-rays) in any occupation involving direct contact with, handling thereof, or exposure thereto.

(g) Poisoning by, or ulceration from, chromic acid, or bichromate of ammonium, bichromate of potassium, or bichromate of sodium, or their preparations, in any occupation involving direct contact with, handling thereof, or exposure thereto.

(h) Epitheliomatous cancer or ulceration due to tar, pitch, bitumen, mineral oil, or paraffin, or any compound, product or residue of any of those substances, in any occupation involving direct contact with, handling thereof, or exposure thereto.

(i) Infection or inflammation of the skin due to oils, cutting compounds, lubricants, dust, liquids, fumes, gases, or vapor, in any occupation involving direct contact with, handling thereof, or exposure thereto.

(j) Anthrax occurring in any occupation involving the handling of or exposure to wool, hair, bristles, hides, or skins, or bodies of animals either alive or dead.

(k) Silicosis, anthraco-silicosis or coal worker's pneumoconiosis (the latter two commonly known as Miner's Asthma and hereinafter referred to as anthraco-silicosis or coal worker's pneumoconiosis) in any occupation involving direct contact with, handling of, or exposure to the dust of anthracite or bituminous coal and/or dust of silicon dioxide (SiO_2).

(l) Asbestosis in any occupation involving direct contact with, handling of, or exposure to the dust of asbestos.

(m) Tuberculosis, Serum Hepatitis or infectious hepatitis in the occupation of nursing or auxiliary services involving exposure to such disease.

(n) All other occupational diseases (1) to which the claimant is exposed by reason of his employment, and (2) which are peculiar to the industry or occupation, and (3) which are not common to the general population. For the purposes of this clause, partial loss of hearing due to noise shall not be considered an occupational disease.

(o) Diseases of the heart and lungs, resulting in either temporary or permanent total or partial disability or death, after four years or more of service in fire fighting for the benefit or safety of the public, caused by extreme over-exertion in times of stress or danger or by exposure to heat,

smoke, fumes or gases, arising directly out of the employment of any such firemen. The Commonwealth shall pay the full amount of compensation for disability under this clause.

Sec 109 No compensation shall be paid for any occupational disease if, during hostile attacks on the United States, disability or death of an employe results solely from military activities of the armed forces of the United States or from military activities or enemy sabotage of a foreign power.

ARTICLE II
Damages by Action at Law

Sec 201 In any action brought to recover damages for disability or death of an employe caused by occupational disease arising out of and in the course of his employment, it shall not be a defense that the occupational disease was caused in whole or in part by the negligence of a fellow employe.

Sec 202 The employer shall be liable for the negligence of employes other than the plaintiff, while acting within the scope of their employment, including engineers, chauffeurs, miners, mine-foremen, fire-bosses, mine superintendents, plumbers, officers of vessels, and all other employes licensed by the Commonwealth or other governmental authority, if the employer be allowed by law the right of free selection of such employes from the class of persons thus licensed; and such employes shall be the agents and representatives of their employers, and their employers shall be responsible for the acts and neglects of such employes, as in the case of other agents and employes of their employers; and, notwithstanding the employment of such employes, the property in and about which they are employed, and the use and operation thereof, shall at all times be under the supervision, management and control of their employers.

Sec 203 An employer who permits the entry upon premises occupied by him or under his control of a laborer or an assistant hired by an employe or contractor who has rejected article three of this act, for the performance upon such premises of a part of the employer's regular business entrusted to such employe or contractor, shall be liable to such laborer or assistant in the same manner and to the same extent as to his own employe.

Sec 204 No agreement, composition, or release of damages made before the date of any disability or death resulting from occupational disease, except the agreement defined in article three of this act, shall be valid or shall bar a claim for damages for such disability or death; and any such agreement other than that defined in article three herein, is declared to be against the public policy of this Commonwealth. The receipt of benefits from any association, society, or fund shall not bar the recovery of damages by action at law, nor the recovery of compensation under article three hereof; and any release executed in consideration of such benefits shall be void; Provided, however, That if the employe receives unemployment compensation benefits, such amount or amounts so received shall be credited as against the amount of the award made under the provisions of the occupational disease act.

Sec 205 If disability or death is compensable under this act, a person shall not be liable to anyone at common law or otherwise on account of such disability or death for any act or omission occurring while such person was in the same employ as the person disabled or killed, except for intentional wrong.

ARTICLE III
Elective Compensation

Sec 301 (a) When employer and employe shall by agreement, either express or implied, as hereinafter provided, accept the provisions of article three of this act, compensation for disability or death of such employe, caused by occupational disease, arising out of and in the course of his employment, shall be paid by the employer, without regard to negligence, according to the schedule contained in sections three hundred and six and three hundred and seven of this article, but —

(1) No compensation shall be paid when the disability or death is caused by the employe's violation of law, but the burden of proof of such fact shall be upon the employer.

(2) The maximum compensation payable under this article for disability, and death resulting from silicosis, anthraco-silicosis, coal worker's pneumoconiosis, or asbestosis shall not exceed the sum of twelve thousand seven hundred fifty dollars ($12,750) which shall be full and complete payment for all disability, present or future, or for death from such occupational diseases arising out of employment by any and all employers in this Commonwealth except that any employe who has received the maximum compensation herein or heretofore payable shall be paid additional compensation in the amount of seventy-five dollars ($75) per month for each month of total disability occurring subsequent to the month in which such maximum compensation was received: Provided, That in the case of any employe who received the maximum compensation herein or heretofore payable prior to the effective date of this amending act, such additional compensation shall commence only with the month this amending act becomes effective. Such additional compensation which is paid to an employe who, on the effective date of this amending act, is receiving compensation or has theretofore received the maximum compensation prescribed, shall be paid by the Commonwealth. Such additional compensation paid to an employe who first becomes entitled to compensation subsequent to the effective date of this amending act and who exhausts the maximum compensation prescribed, shall be paid from the same source or sources and in the same manner as the prescribed maximum compensation was paid.

(b) The right to receive compensation under this act shall not be affected by the fact that a minor is employed or is permitted to be employed in violation of the laws of this Commonwealth relating to the employment of minors, or that he obtained his employment by misrepresenting his age.

(c) Compensation for the occupational diseases enumerated in this act shall be paid only when such occupational disease is peculiar to the occupation or industry in which the employe was engaged and not common to the general population. Wherever compensable disability or death is mentioned as a cause for compensation under this act, it shall mean only compensable disability or death resulting from occupational disease and occurring within four years after the date of his last employment in such occupation or industry.

(d) Compensation for silicosis, or anthraco-silicosis, coal worker's pneumoconiosis and asbestosis, shall be paid only when it is shown that the employe has had an aggregate employment of at least two years in the Commonwealth of Pennsylvania, during a period of ten years next preceding the date of disability, in an occupation having a silica, coal or asbestos hazard.

(e) Compensation shall not be payable for partial disability due to silicosis, anthraco-silicosis, coal worker's pneumoconiosis, or asbestosis. Compensation shall be payable, as otherwise provided in this act, for total disability or death caused by silicosis, anthraco-silicosis, coal worker's pneumoconiosis, or asbestosis, or by silicosis, anthraco-silicosis, coal worker's pneumoconiosis, or asbestosis, when accompanied by active pulmonary tuberculosis.

(f) If it be shown that the employe, at or immediately before the date of disability, was employed in any occupation or industry in which the occupational disease is a hazard, it shall be presumed that the employe's occupational disease arose out of and in the course of his employment, but this presumption shall not be conclusive.

(g) The employer liable for the compensation provided by this article shall be the employer in whose employment the employe was last exposed to the hazard of the occupational disease claimed, regardless of the length of time of such last exposure: Provided, That when a claimant alleges that disability or death was due to silicosis, anthraco-silicosis, coal worker's pneumoconiosis, asbestosis or any other occupational disease which developed to the point of disablement only after an exposure of five or more years, the only employer liable shall be the last employer in whose employment the employe was last exposed to the hazard of such occupational disease during a period of six months or more: And provided further, That in those cases where disability or death is not conclusively proven to be the result of such last exposure, all compensation shall be paid by the Commonwealth. An exposure during a period of less than six months after the effective date of this act shall not be deemed an exposure. The notice of disability or death and claim shall be made to the employer who is liable under this subsection, his insurance carrier, if any, and the Commonwealth.

(h) Except as hereinafter provided, all compensation payable under this article shall be payable in periodic installments, as the wages of the employe were payable before the accident.

(i) Notwithstanding any other provisions of this act, compensation for silicosis, anthraco-silicosis, coal worker's pneumoconiosis, and asbestosis shall be paid for each month beginning with the month this amending act becomes effective, or beginning with the first month of disability, whichever occurs later, at the rate of seventy-five dollars ($75) per month, to every employe totally disabled thereby as a result of exposure thereto, who has not theretofore been compensated because his claim was barred by any of the time limitations prescribed by this act, and shall continue during the period of such total disability. No compensation under this section shall be paid to any employe who has not been exposed to a silica, coal, or asbestos hazard within the Commonwealth of Pennsylvania for a period of two years. Subsequent to the effective date of this amending act of 1969, it shall be necessary to be a resident of Pennsylvania in order to qualify for compensation, but not to continue receiving the same after qualification. All such compensation to those whose last exposure precedes the effective date of this amending act shall be paid by the Commonwealth. Employes whose last exposure follows the effective date of this amending act and who become entitled to the compensation provided by this subsection shall be paid as provided by this act.

An application for compensation under this subsection shall not be accepted from any person who, during the preceding six months has been determined to be ineligible hereunder.

Every application shall be accompanied by two prints of the same recent photograph of the applicant, and such other proof of identity as the board shall require. One of the prints shall be stamped by the board and returned to the applicant, who shall deliver it to the physician at the time of examination. The physician shall attach the print to his report to the board.

(j) Every person heretofore or hereafter qualified for additional compensation under the provisions of clause 2 of subsection (a) or subsection (i) of this section shall, beginning with the month following the effective date of this amending act of 1969, or the month of qualification, whichever occurs later, be paid further compensation of twenty-five dollars ($25) per month during the period of disability. Such further compensation paid to a person heretofore qualified shall be paid by the Commonwealth. Compensation paid to any person hereafter qualified shall be paid from the same source as the additional compensation provided in clause 2 of subsection (a) or subsection (i) of this section.

(k) Upon the award of any benefits under the Federal Coal Mine Health and Safety Act of 1969 to a person who is also receiving or claiming monthly compensation totally funded by general revenues of the Commonwealth of Pennsylvania under subsections (a), (i), (j), or (l) of section 301, such person shall have his monthly compensation from general revenues of the Commonwealth suspended effective with the month following the month of award of Federal benefits, as may be evidenced by a copy of the Federal award certificate, or effective with the month of enactment of this amendment, whichever is later. Upon any future action by the United States Congress, Federal executive departments, or Federal courts which would make present recipients under the Pennsylvania Occupational Disease Act eligible for both Federal and State payments, the sum of which would exceed the maximum authorized Federal payment, the eligible recipients would then receive retroactively all State payments that were suspended under the authority of this act. All such recipients who have their State payments suspended shall continue their eligibility and entitlement under the Pennsylvania Occupational Disease Act and at any time in the future for whatever reason that such recipients' payments under the Federal law are terminated, suspended or reduced their State payments shall be reinstituted effective with the month following the month that Federal benefits are terminated, suspended or reduced. The recipients' entitlement to weekly compensation and the maximum sum thereof provided under clause 2 of subsection (a) of section 301 shall remain unchanged, and no reduction shall be made in the medical and hospital compensation payable under subsection (f) of section 306 or in the burial expenses payable under clause 8 of section 307.

(l) Every person heretofore or hereafter qualified for additional compensation under the provisions of clause (2) of subsection (a) or subsection (i) shall, beginning with the month following the effective date of this amending act, or the month of qualification, whichever occurs later, be paid further compensation of twenty-five dollars ($25) per month during the period of disability. Such further compensation paid to a person heretofore or hereafter qualified shall be paid by the Commonwealth.

(m) Every person heretofore or hereafter qualified for additional compensation under the provisions of clause (2) of subsection (a) or subsection (i) shall, beginning with the month following the effective date of this subsection, or the month of qualification, whichever occurs later, be paid further compensation of fifty dollars ($50) per month during the period of disability. Such further compensation paid to a person heretofore or hereafter qualified shall be paid by the Commonwealth.

Sec 302 (a) In every contract of hiring made after October first, one thousand nine hundred and thirty-nine, and in every contract of hiring renewed or extended by mutual consent, expressed or implied, after said date, it shall be conclusively presumed that the parties have accepted the provisions of article three of this act, and have agreed to be bound thereby, unless the employer shall post at this plant, office or place of business a notice of his intention not to pay such compensation or unless there be, at the time of the making, renewal, or extension of such contract, an express statement in writing, from either party to the other, that the provisions of article three of this act are not intended to apply, and unless a true copy of such posted notice or such written statement, accompanied by proof of posting or proof of service thereof upon the other party, setting forth under oath or affirmation the time, place, and manner of such posting or service, be filed with the department within twenty days after such posting or service. Every contract of hiring, oral, written, or implied from circumstances, now in operation, or made or implied on or before October first, one thousand nine hundred and thirty-nine, shall be conclusively presumed to continue subject to the provisions of article three hereof, unless the employer shall on or before said date either post at his plant, office or place of business a notice of his intention not to pay such compensation or unless either party shall, on or before said date, in writing, have notified the other party to such contract that the provisions of article three hereof are not intended to apply, and unless there shall be filed with the department a true copy of such notice, together with proof of posting or service, within the time and in the manner hereinabove prescribed: Provided, however, That the provisions of this section shall not be so construed as to impair the obligation of any contract now in force. Such posted notice shall constitute sufficient notice to all employes and to the parents and guardians of all minor employes, and a certified copy of proof of posting or proof of service shall be

prima facie evidence of notice. It shall not be lawful for any officer or agent of this Commonwealth, or for any county, city, borough, town, or township therein, or for any officer or agent thereof, or for any other governmental authority created by the laws of this Commonwealth, to give such notice of rejection of the provisions of this article to any employe of the Commonwealth or of such governmental agency.

(b) After October first, one thousand nine hundred and thirty-nine, an employer who permits the entry, upon premises occupied by him or under his control, of a laborer or an assistant hired by an employe or contractor, for the performance upon such premises of a part of the employer's regular business entrusted to that employe or contractor, shall be conclusively presumed to have agreed to pay to such laborer or assistant compensation in accordance with the provisions of article three, unless the employer shall post at his plant, office or place of business a notice of his intention not to pay such compensation, and unless there be filed with the department within twenty days, thereafter, a true copy of such notice, together with proof of the posting of the same, setting forth upon oath or affirmation the time, place, and manner of such posting; and after October first, one thousand nine hundred and thirty-nine, any such laborer or assistant who shall enter upon premises occupied by or under control of such employer, for the purpose of doing such work, shall be conclusively presumed to have agreed to accept the compensation provided in article three, in lieu of his right of action under article two, unless he shall have given notice in writing to the employer, at the time of entering upon such employer's premises for the purpose of doing his work, of his intention not to accept such compensation, and unless within twenty days thereafter there shall have been filed with the department a true copy of such notice, accompanied by proof of service thereof upon such employer, setting forth under oath or affirmation the time, place, and manner of such service. And in such cases where article three binds such employer and such laborer or assistant, it shall not be in effect between the intermediate employer or contractor and such laborer or assistant, unless otherwise expressly agreed.

(c) Any notice given hereunder by an employer to his employes need not be addressed to each employe individually, but may be addressed to all employes. Proof of service of any number of statements or notices may be made in one affidavit, but such affidavit shall state the time and place of each service.

Sec 303 Such agreement shall constitute an acceptance of all the provisions of article three of this act, and shall operate as a surrender by the parties thereto of their rights to any form or amount of compensation or damages for any disability or death resulting from occupational disease, or to any method of determination thereof, other than as provided in article three of this act. Such agreement shall bind the employer and his personal representatives, and the employe, his or her wife, or husband, widow or widower, next of kin, and other dependents.

Sec 304 Any agreement between employer and employe for the operation or nonoperation of the provisions of article three of this act may be terminated by the posting of notice by the employer or by either party upon thirty days' notice to the other in writing, if a copy of such notice, with proof of posting or proof of service, be filed in the department as provided in section three hundred and two of this article.

Sec 304.1 The Secretary of Labor and Industry shall, within ninety (90) days after the effective date of this amendatory act, prepare a brochure of instructions, setting forth the rights of an employe in the event of disability or death caused by occupational disease and informing him of the time and manner in which claims should be filed. A copy of such brochure shall be provided to each insurance company authorized to write insurance policies covering occupational diseases under this act. Such insurance companies shall prepare at their own expense copies of said brochure for distribution to such insured employers. Each insurance company shall prepare the brochures immediately upon receipt of the sample brochure from the Secretary of Labor and Industry in such quantity as required by employers for distribution to each employe. The employer shall distribute such brochures to each employe at the time of hiring and to each existing employe within thirty (30) days after the receipt of the brochure.

Sec 305 Every employer liable under this act to pay compensation shall insure the payment of compensation in the State Workmen's Insurance Fund, or in any insurance company, or mutual association or company, authorized to insure such liability in this Commonwealth, unless such employer shall be exempted by the department from such insurance. Such insurer shall assume the employer's liability hereunder and shall be entitled to all of the employer's immunities and protection hereunder except, that whenever any employer shall have purchased insurance to provide benefits under this act to persons excluded from the definition of "employe" under section 104 of this act by virtue of being engaged in domestic service or agriculture, neither the employer nor the insurer shall be entitled to raise the defense of such exclusion. An employer desiring to be exempt from insuring the whole or any part of his liability for compensation shall make application to the department, showing his financial ability to pay such compensation, whereupon the department, if the applicant establishes his financial ability, shall issue to the applicant a permit authorizing such exemption. The department shall establish a period of twelve calendar months, to begin and end at such times as the department shall prescribe, which shall be known as the annual exemption period. Unless previously revoked, all permits issued under this section shall expire and terminate on the last day of the annual exemption period for which they were issued. Permits issued under this act shall be renewed upon the filing of an application. The department may, from time to time, require further statements of the financial ability of such employer, and, if at any time such employer appears no longer able to pay compensation, shall revoke its permit granting exemption, in which case the employer shall immediately subscribe to the State Workmen's Insurance Fund or insure his liability in any insurance company or mutual association or company, as aforesaid.

Any employer who fails to comply with the provisions of this section for every such failure shall, upon summary conviction before any official of competent jurisdiction, be sentenced to pay a fine of not less than one hundred dollars or more than five hundred dollars, and costs of prosecution, or imprisonment for a period of not more than six months, or both. Every day's violation shall constitute a separate offense. It shall be the duty of the department to enforce the provisions of this section; and it shall investigate all violations that are brought to its notice and shall institute prosecutions for violations thereof. All fines recovered under the provisions of this section shall be paid to the department and by it paid into the State Treasury.

Sec 306 The following schedule of compensation is hereby established subject to the limitations of section 301:

(a) For total disability, sixty-six and two-thirds per centum of the wages of the disabled employe as defined in section three hundred and nine, beginning after the seventh day of total disability, and payable for the duration of total disability, but the compensation shall not be more than sixty dollars per week nor less than thirty-five dollars per week. If at the time when disability begins, the employe receives wages of thirty-five dollars per week or less, then he shall receive ninety per centum of the wages per week as compensation, but in no event less than twenty-two dollars per week. Nothing in this clause shall require payment of compensation after disability shall cease.

(b) For disability partial in character (except the particular cases mentioned in clause (c)) sixty-six and two-thirds per centum of the difference between the wages of the disabled employe, as defined in section three hundred and nine, and the earning power of the employe thereafter; but such compensation shall not be more than forty-five dollars per week. This compensation shall be paid during the period of such partial disability except as provided in clause (e) of this section, but not more than three hundred and fifty weeks. Should total disability be followed by partial disability, the period of three hundred and fifty weeks shall not be reduced by the number of weeks during which compensation was paid for total disability. The term "earning power," as used in this section, shall in no case be less than the weekly amount which the employe receives after disability begins, and in those cases in which the employe works fewer than five days per week for reasons not connected with or arising out of the disability resulting from the injury shall not be less than five times his actual daily wage as fixed by the day, hour, or by the output of the employe, and in no instance shall an employe receiving compensation under this section receive more in compensation and wages combined than a

fellow employe in employment similar to that in which the injured employe was engaged at the time of disability.

(c) For all disability resulting from loss or loss of the use of members resulting from occupational disease, the compensation shall be exclusively as follows:

For the loss of a hand, sixty-six and two-thirds per centum of wages during one hundred and seventy-five weeks.

For the loss of a forearm, sixty-six and two-thirds per centum of wages during one hundred and ninety-five weeks.

For the loss of an arm, sixty-six and two-thirds per centum of wages during two hundred and fifteen weeks.

For the loss of a foot, sixty-six and two-thirds per centum of wages during one hundred and fifty weeks.

For the loss of a lower leg, sixty-six and two-thirds per centum of wages during one hundred and eighty weeks.

For the loss of a leg, sixty-six and two-thirds per centum of wages during two hundred and fifteen weeks.

For the loss of an eye, sixty-six and two-thirds per centum of wages during one hundred and fifty weeks.

For the complete loss of hearing in both ears, sixty-six and two-thirds per centum of wages during one hundred and eighty weeks.

For the loss of a thumb, sixty-six and two thirds per centum of wages during sixty weeks.

For the loss of a first finger, commonly called index finger, sixty-six and two-thirds per centum of wages during thirty-five weeks.

For the loss of a second finger, sixty-six and two-thirds per centum of wages during thirty weeks.

For the loss of a third finger, sixty-six and two-thirds per centum of wages during twenty weeks.

For the loss of a fourth finger, commonly called little finger, sixty-six and two-thirds per centum of wages during fifteen weeks.

The loss of the first phalange of the thumb shall be considered the loss of the thumb. The loss of a substantial part of the first phalange of the thumb shall be considered the loss of one-half of the thumb.

The loss of any substantial part of the first phalange of a finger, or an amputation immediately below the first phalange for the purpose of providing an optimum surgical result, shall be considered the loss of one-half of the finger. Any greater loss shall be considered the loss of the entire finger.

The loss of one-half of the thumb or a finger shall be compensated at the same rate as for the loss of a thumb or finger, but for one-half of the period provided for the loss of a thumb or finger.

For the loss of, or permanent loss of the use of, any two or more such members, not constituting total disability, sixty-six and two-thirds per centum of wages during the aggregate of the periods specified for each.

For the loss of a great toe, sixty-six and two-thirds per centum of wages during forty weeks.

For the loss of any other toe, sixty-six and two-thirds per centum of wages during sixteen weeks.

The loss of the first phalange of the great toe, or of any toe, shall be considered equivalent to the loss of one-half of such great toe, or other toe, and shall be compensated at the same rate as for the loss of a great toe, or other toe, but for one-half of the period provided for the loss of a great toe or other toe.

The loss of more than one phalange of a great toe, or any toe, shall be considered equivalent to the loss of the entire great toe or other toe.

For the loss of, or permanent loss of the use of any two or more such members, not constituting total disability, sixty-six and two-thirds per centum of wages during the aggregate of the periods specified for each.

Unless the board shall otherwise determine, the loss of both hands or both arms or both feet or both legs or both eyes shall constitute total disability, to be compensated according to the provisions of clause (a).

Amputation at the wrist shall be considered as the equivalent of the loss of a hand, and amputation at the ankle shall be considered as the equivalent of the loss of a foot. Amputation between the wrist and the elbow shall be considered as the loss of a forearm, and amputation between the ankle and the knee shall be considered as the loss of a lower leg. Amputation at or above the elbow shall be considered as the loss of an arm and amputation at or above the knee shall be considered as the loss of a leg. Permanent loss of the use of a hand, arm, foot, leg, eye, finger, or thumb, great toe or other toe, shall be considered as the equivalent of the loss of such hand, arm, foot, leg, eye, finger, or thumb, great toe or other toe.

In addition to the payments hereinbefore provided for disabilities of the classes specified, any period of disability necessary and required as a healing period shall be compensated in accordance with the provisions of this subsection. The healing period shall end (I) when the claimant returns to employment without impairment in earnings, or (II) on the last day of the period specified in the following table, whichever is the earlier:

For the loss of a hand, twenty weeks.

For the loss of a forearm, twenty weeks.

For the loss of an arm, twenty weeks.

For the loss of a foot, twenty-five weeks.

For the loss of the lower leg, twenty-five weeks.

For the loss of a leg, twenty-five weeks.

For the loss of an eye, ten weeks.

For the loss of hearing, ten weeks.

For the loss of a thumb or any part thereof, ten weeks.

For the loss of any other finger or any part thereof, six weeks.

For the loss of a great toe or any part thereof, twelve weeks.

For the loss of any other toe or any part thereof, six weeks.

This compensation shall not be more than sixty dollars per week nor less than thirty-five dollars per week: Provided, That if at the time of disability the employe receives wages of thirty-five dollars per week or less, then he shall receive ninety per centum of such wages per week as compensation, but in no event less than twenty-two dollars per week. When an employe works during the healing period, his wages and earning power shall be as defined in this act, and he shall not receive more in wages and compensation combined than his wages at the time of disability as defined in section 309. Where any such injury or injuries shall require an amputation at a time after the end of the healing period hereinbefore provided, the employe shall be entitled to receive compensation for the second healing period, and in the case of a second injury or amputation to the same limb prior to the expiration of their first healing period, a new healing period shall commence for the period hereinbefore provided and no further compensation shall be payable for the first healing period.

(d) Where, at the time of disability, the employe incurs other disabilities, separate from those which result in permanent disabilities enumerated in clause (c) of this section, the number of weeks for which compensation is specified for the permanent disabilities shall begin at the end of the period of temporary total disability which results from the other separate disability, but in that event the employe shall not receive compensation provided in clause (c) of this section for the specific healing period. In the event the employe incurs two or more permanent disabilities of the above enumerated classes compensable under clause (c) of this section, he shall be compensated for the largest single healing period rather than the aggregate of the healing periods.

(e) No compensation shall be allowed for the first seven days after disability begins, except as provided in this clause (e) and clause (f) of this section. If the period of disability lasts more than six weeks after disability begins, the employe shall also receive compensation for the first seven days of disability.

(f) During the first six months after disability begins, the employer shall furnish reasonable surgical and medical services, medicines, and supplies, as and when needed, unless the employe refuses to allow them to be furnished by the employer. The cost of such services, medicines, and supplies, shall not exceed seven hundred fifty dollars. If the employer shall, upon application made to him, refuse to furnish such services, medicines, and supplies, the employe may procure same and shall receive from the employer the reasonable cost thereof within the above limitations. In addition to the above service, medicines, and supplies, hospital treatment, services, and supplies and orthopedic appliances and prostheses, shall be furnished by the employer for the said period of six months. The board may order further medical, surgical and hospital services if it is established that further care will result in restoring the disabled employe's earning power to a substantial degree. In each order the board shall specify the maximum period and the maximum costs of the treatment designed for the employe's rehabilitation. The cost of such hospital treatment, service, and supplies, shall not in any case exceed the prevailing charge in the hospital for like services to other individuals. If the employe shall refuse reasonable surgical, medical, and hospital services, medicines, and supplies, tendered to him by his employer, he shall forfeit all rights to compensation for disability or any increase in his disability shown to have resulted from such refusal. Whenever an employe shall have suffered the loss of a limb, part of a limb, or an eye, the employer shall furnish to the employe in addition to the aforementioned surgical and medical services, services rendered by duly licensed practitioners of the healing arts, medicines and supplies, or artificial limb or eye or other prostheses of a type and kind recommended by the doctor attending such employe in connection with such injury as well as such training as may be required in

the proper use of such prostheses. The provisions of this section shall apply to occupational diseases where no loss of earning power occurs.

(g) Should the employe die from some other cause than the occupational disease, the liability for compensation shall cease.

Sec 307 In case of death resulting from occupational disease, compensation shall be computed on the following basis, and distributed to the following persons, subject to the limitations of section 301:

(1) If there be no widow nor widower entitled to compensation, compensation shall be paid to the guardian of the child or children, or if there be no guardian, to such other persons as may be designated by the board as hereinafter provided, as follows:

(a) If there be one child, thirty-two per centum of wages of deceased, but not in excess of twenty-five dollars per week.

(b) If there be two children, forty-two per centum of wages of deceased, but not in excess of thirty-three dollars per week.

(c) If there be three children, fifty-two per centum of wages of deceased, but not in excess of forty-one dollars per week.

(d) If there be four children, sixty-two per centum of wages of deceased, but not in excess of forty-eight dollars per week.

(e) If there be five children, sixty-four per centum of wages of deceased, but not in excess of fifty-four dollars per week.

(f) If there be six or more children, sixty-six and two-thirds per centum of wages of deceased, but not in excess of sixty dollars per week.

(2) To the widow or widower, if there be no children, fifty-one per centum of wages, but not in excess of thirty-nine dollars per week.

(3) To the widow or widower, if there be one child, sixty per centum of wages, but not in excess of forty-six dollars per week.

(4) To the widow or widower, if there be two children, sixty-six and two-thirds per centum of wages, but not in excess of fifty-four dollars per week.

(5) To the widow or widower, if there be three or more children, sixty-six and two-thirds per centum of wages, but not in excess of sixty dollars per week.

(6) If there be neither widow, widower, nor children, entitled to compensation, then to the father or mother, if dependent to any extent upon the employe at the time of his death, thirty-two per centum of wages, but not in excess of twenty-five dollars per week: Provided, however, That in the case of a minor child who has been contributing to his parents, the dependency of said parents shall be presumed: And provided further, That if the father and mother was totally dependent upon the deceased employe at the time of his death, the compensation payable to such father or mother shall be fifty-two per centum of wages, but not in excess of thirty-eight dollars per week.

(7) If there be neither widow, widower, children, nor dependent parent, entitled to compensation, then to the brothers and sisters, if actually dependent upon the decedent for support at the time of his death,

twenty-two per centum of wages for one brother or sister, and five per centum additional for each additional brother or sister, with a maximum of thirty-two per centum, such compensation to be paid to their guardian, or, if there be no guardian, to such other person as may be designated by the board, as hereinafter provided.

(8) Whether or not there be dependents as aforesaid, the reasonable expense of burial, not exceeding seven hundred fifty dollars, which shall be paid by the employer or insurer directly to the undertaker (without deduction of any amounts theretofore paid for compensation or for medical expenses).

Compensation shall be payable under this section to or on account of any child, brother, or sister, only if and while such child, brother, or sister is under the age of eighteen. No compensation shall be payable under this section to a widow, unless she was living with her deceased husband at the time of his death, or was then actually dependent upon him and receiving from him a substantial portion of her support. No compensation shall be payable under this section to a widower, unless he be incapable of self-support at the time of his wife's death and be at such time dependent upon her for support. If members of decedent's household at the time of his death, the terms "child" and "children" shall include stepchildren, adopted children and children to whom he stood in loco parentis, and shall include posthumous children. Should any dependent of a deceased employe die or remarry, or should the widower become capable of self-support, the right of such dependent or widower to compensation under this section shall cease: Provided, however, That if, upon investigation and hearing, it shall be ascertained that the widow or widower is living with a man or woman, as the case may be, in meretricious relationship and not married, or the widow living a life of prostitution, the board may order the termination of compensation payable to such widow or widower. If the compensation payable under this section to any person shall for any cause, cease, the compensation to the remaining persons entitled thereunder shall thereafter be the same as would have been payable to them had they been the only persons entitled to compensation at the time of the death of the deceased.

The wages upon which death compensation shall be based shall not in any case be taken to exceed ninety dollars per week, nor be less than fifty dollars per week.

The board may, if the best interests of a child or children shall so require, at any time order and direct the compensation payable to a child or children, or to a widow or widower, on account of any child or children, to be paid to the guardian of such child or children, or, if there be no guardian, to such other person as the board, as hereinafter provided, may direct. If there be no guardian or committee of any minor, dependent, or insane employe, or dependent, on whose account compensation is payable, the amount payable on account of such minor, dependent, or insane employe, or dependent may be paid to any surviving parent, or to such other person as the board may order and direct, and the board may require any person, other than a guardian or committee, to whom it has directed compensation for a minor, dependent, or insane employe, or dependent to be paid, to render, as and when it shall so order, accounts of the receipts and disbursements of such person, and to file with it a satisfactory bond in a sum sufficient to secure the proper application of the moneys received by such person.

Sec 308 (a) When compensation is awarded because of disability or death caused by silicosis, anthraco-silicosis, coal worker's pneumoconiosis, asbestosis, or any other occupational disease which developed to the point of disablement only after an exposure of five or more years, the compensation for disability or death due to such disease shall, except as otherwise provided in subsection (g) of section 301, be paid jointly by the employer and the Commonwealth and the employer shall be liable for sixty per centum of the compensation due and the Commonwealth forty per centum.

(b) Compensation payable by the Commonwealth under subsection (a) of this section shall be paid out of appropriations made from time to time to the department out of the General Fund in the State Treasury.

(c) In all claims for compensation partially payable by the Commonwealth under subsection (a) of this section, the department shall be designated as a codefendant.

(d) In all agreements for the payment of compensation and all awards, the amount payable by the employer and the amount payable by the Commonwealth shall be separately stated. An award against the employer shall be for only the percentage of the total compensation which the employer is obligated to pay under subsection (a) of this section, not to exceed the stated percentage of the maximum payable by the employer under section 301(a)2 of this act, or if section 301(a)2 be inapplicable, then under sections 306 and 307 of this act. A separate award shall be made against the Commonwealth for the balance of the compensation payable under said sections, which shall be payable out of appropriations made as aforesaid. Nothing in this section shall prohibit the Commonwealth from entering into agreements to pay the compensation for which it is liable: Provided, however, That where compensation is payable under the provisions of subsection (a) of this section, the Commonwealth shall not enter into an agreement unless the employer is a party to the agreement: And, provided further, That any such agreement shall contain facts sufficient to entitle the claimant to compensation and shall be accompanied by a supporting medical certificate. All such agreements shall be approved by the board or by a referee.

Sec 309 Whenever in this article the term "wages" is used, it shall be construed to mean the average weekly wages of the employe, ascertained as follows:

(a) If at the time of the disability the wages are fixed by the week, the amount so fixed shall be the average weekly wage.

(b) If at the time of the disability the wages are fixed by the month, the average weekly wage shall be the monthly wage so fixed, multiplied by twelve and divided by fifty-two.

(c) If at the time of the disability the wages are fixed by the year, the average weekly wage shall be the yearly wage so fixed, divided by fifty-two.

(d) If at the time of the disability the wages are fixed by the day, hour, or by the output of the employe, the average weekly wage shall be the wage most favorable to the employe, computed by dividing by thirteen the total wages of said employe earned in the employ of the employer in the first, second, third, or fourth period of thirteen consecutive calendar weeks in the fifty-two weeks immediately preceding the disability, or in case the employe receives wages monthly or semi-monthly, by dividing by thirteen the total wages of said employe earned in the employ of the employer in the first, second, third, or fourth period of three consecutive calendar months in the year immediately preceding the disability.

If the employe has been in the employ of employer less than thirteen calendar weeks, (or three calendar months if the employe receives wages monthly, or semi-monthly) immediately preceding the disability, his average weekly wage shall be computed under the foregoing paragraph, taking "total wages" for such purpose to be the amount he would have earned had he been so employed by employer the full thirteen calendar weeks, (or three calendar months) immediately preceding the disability, and had worked when work was available to other employes in a similar occupation, unless it be conclusively shown that, by reason of exceptional causes, such method of computation does not ascertain fairly the "total wages" of the employe so employed less than thirteen calendar weeks (or three calendar months).

(e) In occupations which are exclusively seasonal, and therefore cannot be carried on throughout the year, the average weekly wage shall be taken to be one-fiftieth of the total wages which the employe has earned from all occupations during the twelve calendar months immediately preceding the disability, unless it be shown that during such year, by reason of exceptional causes, such method of computation

does not ascertain fairly the earnings of the employe, in which case the period for calculation shall be extended so far as to give a basis for the fair ascertainment of his average weekly earnings.

The terms "average weekly wage" and "total wages," as used in this section, shall include board and lodging received from the employer, and when so received, the board shall be rated at two dollars per day if more than one meal is served, and one dollar per day if only one meal is served, and lodging shall be rated at one dollar and fifty cents per day. In employment in which employes customarily receive not less than one-third of their remuneration in tips or gratuities not paid by the employer, gratuities shall be added to the wages received at the rate of two dollars per day; but such terms shall not include amounts deducted by the employer under the contract of hiring for labor furnished, or paid for by the employer, and necessary for the performance of such contract by the employe nor shall such terms include deductions from wages due the employer; for rent, and supplies necessary for the employe's use in the performance of his labor.

Where the employe is working under concurrent contracts with two or more employers, and the defendant employer has knowledge of such employment prior to the disability, his wages from all such employers shall be considered as if earned from the employer liable for compensation.

If under clauses (a), (b), (c), (d) and (e) of this section the amount determined is less than if computed as follows, this computation shall apply, viz: divide the total wages earned by the employe during the last two completed calendar quarters with the same employer by the number of days he worked for such employer during such period multiplied by five.

The weekly wage upon which compensation shall be computed, shall be the wage earned by the employe in his last employment in the occupation or industry in which the occupational disease is a hazard.

Sec 310 Alien widows, children and parents, not residents of the United States, shall be entitled to compensation, but only to the amount of fifty per centum of the compensation which would have been payable if they were residents of the United States: Provided, That compensation benefits are granted residents of the United States under the laws of the foreign country in which the widow, children or parents reside. Alien widowers, brothers and sisters who are not residents of the United States shall not be entitled to receive any compensation. In no event shall any nonresident alien widow or parent be entitled to compensation in the absence of proof that the alien widow or parent has actually been receiving a substantial portion of his or her support from the decedent. Where transmission of funds in payment of any such compensation is prohibited by any law of the Commonwealth or of the United States to residents of such foreign country, then no compensation shall accrue or be payable while such prohibition remains in effect and, unless such prohibition is removed within six years from the date of death, all obligation to pay compensation under this section shall be forever extinguished.

In every instance where an award is made to alien widows, children or parents, not residents in the United States, the referee or the board shall, in the award, fix the amount of any fee allowed to any person for services in connection with presenting the claim, and it shall be a misdemeanor punishable by a fine of not more than five hundred dollars, or imprisonment for not more than six months, or both, to accept any remuneration for the services other than that provided by the referee or board.

Sec 311 Unless the employe or someone in his behalf, or some of the dependents or someone in their behalf, shall give notice of disability to the employer liable for compensation under this article, within twenty-one days after compensation disability begins, no compensation shall be due until such notice be given, and unless such notice be given within one hundred and twenty days after the beginning of compensable disability no compensation shall be allowed.

Sec 312 The notice referred to in section three hundred and eleven shall inform the employer that a certain employe became disabled as a result of the occupational disease, described in ordinary language, in the course of his employment on or about a specified time.

Sec 313 The notice referred to in sections three hundred and eleven and three hundred and twelve may be given to the immediate or other superior of the employe, to the employer, or any agent of the employer regularly employed at the place of employment of the disabled employe.

Sec 314 At any time after disability begins, the employe must submit himself for examination, at some reasonable time and place, to a physician or physicians legally authorized to practice under the laws of such place, who shall be selected and paid for by the employer, or the Commonwealth, and the report of the examination of the physician, with his testimony, shall be made a part of the record before a claim for disability shall be allowed by the referee of the Board: Provided, That in the case where there has been an examination by a physician selected and paid for by the Commonwealth, there shall be, in addition an examination by an independent physician selected and paid for by the employer, who shall file a report and testify and who shall not be allowed under any circumstances to adopt the report or the testimony or the examination of the physician of any other party. If the employe shall refuse to submit to the examination by the physician or physicians selected by the employer or the Commonwealth, the board shall order the employe to submit to an examination at a time and place set by it and by the physician or physicians selected and paid by the employer or the Commonwealth, or by a physician or physicians designated by it and paid by the employer or the Commonwealth. The board may at any time after such first examination order the employe to submit himself to such further examinations as it shall deem reasonable and necessary, at such times and places and by such physicians as it may designate; and, in such case, the employer or the Commonwealth shall pay the fees and expenses of the examining physician or physicians, and the reasonable traveling expenses and loss of wages incurred by the employe in order to submit himself to such examination. The refusal or neglect, without reasonable cause or excuse, of the employe to submit to such examination ordered by the board, either before or after an agreement or award, shall deprive him of the right to compensation under this article, during the continuance of such refusal or neglect, and the period of such neglect or refusal shall be deducted from the period during which compensation would otherwise be payable.

The employe shall be entitled to have a physician or physicians of his own selection, to be paid by him, participate in any examination ordered by the board.

Sec 315 In cases of disability all claims for compensation shall be forever barred, unless, within sixteen months after compensable disability begins, the parties shall have agreed upon the compensation payable under this article, or unless, within sixteen months after compensable disability begins, one of the parties shall have filed a petition as provided in article four hereof. Where, however, a person is receiving benefits pursuant to the act of June 28, 1935 (P.L. 477, No. 193), referred to as the Heart and Lung Act, the sixteen-month period in which parties must agree on compensation payable or file a petition for compensation in cases of personal injury or cases of death, shall not begin to run until the expiration of the receipt of benefits pursuant to the Heart and Lung Act. In cases of death all claims for compensation shall be forever barred, unless, within sixteen months after the death, the parties shall have agreed upon the compensation payable under this article, or unless, within sixteen months after the death, one of the parties shall have filed a petition as provided in article four hereof. Where, however, payments of compensation have been made in any case, said limitations shall not take effect until the expiration of sixteen months from the time of the making of the most recent payment made prior to the date of filing such petition.

In cases of total disability from silicosis, anthracosilicosis, coal worker’s pneumoconiosis, and asbestosis where the claim is allowed, compensation shall be payable and commence as of the date the claim is filed.

Sec 316 The compensation contemplated by this article may at any time be commuted by the board, at its then value when discounted at five per centum interest, with annual rests, upon application of either party, with due notice to the other, if it appears that such commutation will be for the best interest of the employe or the

dependents of the deceased employe, and that it will avoid undue expense or undue hardship to either party, or that such employe or dependent has removed or is about to remove from the United States, or that the employer has sold or otherwise disposed of the whole or the greater part of his business or assets: Provided, however, That unless the employer agrees to make such commutation, the board may require the employe or the dependents of the deceased employe to furnish proper indemnity safeguarding the employer's rights.

Sec 317 At any time after the approval of an agreement or after the entry of the award, a sum equal to all further installments of compensation may (where death or the nature of the disability renders the amount of future payments certain), with the approval of the board, be paid by the employer to any savings bank, trust company, or life insurance company, in good standing and authorized to do business in this Commonwealth, and such sum, together with all interest thereon, shall thereafter be held in trust for the employe or the dependents of the employe, who shall have no further recourse against the employer. The payment of such sum by the employer, evidenced by the receipt of the trustee noted upon the prothonotary's docket, shall operate as a satisfaction of said award as to the employer. Payments from said fund shall be made by the trustee in the same amounts and at the same periods as are herein required by the employer, until said fund and interest shall be exhausted. In the appointment of the trustee preference shall be given, in the discretion of the board, to the choice of the employe or the dependents of the deceased employe. Should, however, there remain any unexpended balance of any fund after the payment of all sums due under this act, such balance shall be repaid to the employer who made the original payment, or to his legal representatives.

Sec 318 The right of compensation granted by this article shall have the same preference (without limit of amount) against the assets of an employer, liable for such compensation, as is now or may hereafter be allowed by law for a claim for unpaid wages for labor: Provided, however, That no claim for compensation shall have priority over any judgment, mortgage, or conveyance of land recorded prior to the filing of the petition, award, or agreement as to compensation in the office of the prothonotary of the county in which the land is situated. Claims for payments due under this article of this act and compensation payments made by virtue thereof shall not be assignable, and (except as provided in section three hundred and nineteen of article three and section five hundred and one of article five hereof) shall be exempt from all claims of creditors, and from levy, execution, or attachment, which exemption may not be waived.

Sec 319 Where the compensable disability is caused in whole or in part by the act or omission of a third party, the employer shall be subrogated to the right of the employe, his personal representative, his estate or his dependents, against such third party for the balance of any sum recovered in litigation, or paid in compromise settlement, after subtraction of reasonable attorney's fees and other proper disbursements, but only to the extent of the compensation payable under this article by the employer. Any recovery against such third person in excess of the compensation theretofore paid by the employer shall be paid forthwith to the employe or to the dependents, and shall be treated as an advance payment by the employer on account of any future installments of compensation.

Where an employe has received payments for the disability or medical expense resulting from a disability in the course of his employment, paid by the employer or an insurance company on the basis that the disability was not compensable under this act, in the event of an agreement or award for that disability, the employer or insurance company, who made the payments, shall be subrogated out of the agreement or award to the amount so paid, if the right to subrogation is agreed to by the parties or is established at the time of hearing before the referee or the board.

Sec 320 (a) If the employe is a minor, under the age of eighteen years, employed or permitted to work in violation of any provision of the laws of this Commonwealth relating to minors of such age, compensation, either in the case of disability or death of such employe, shall be one hundred and fifty per centum of the amount that would be payable to such minor if legally employed. The amount by which such compensation shall exceed that provided for in case of legal employment may be referred to as "additional compensation."

(b) The employer and not the insurance carrier shall be liable for the additional compensation. Any provision in an insurance policy undertaking to relieve an employer from such liability shall be void.

(c) Where death or the nature of the disability renders the amount of future payments certain, the total amount of the additional compensation, subject to discount as in the case of commutation, shall be immediately due and payable. It shall be deposited, subject to the approval of the board, in any savings bank, trust company, or life insurance company in good standing and authorized to do business in this Commonwealth.

Where the amount of the future payments of compensation is uncertain, the board shall, upon the approval of the agreement or the entry of an award, determine as nearly as may be the total amount of payment to be made, and the additional compensation so calculated shall, immediately upon such determination, become due and payable by the employer. The amount may be redetermined by the board, and any increase shall then become due and payable, and any excess, which shall be shown to have been paid, shall be returned to the person paying the same. Upon determination of the amount due, it shall be deposited as above provided. Payments of compensation out of deposits shall be made to the employe or dependents as payments of other compensation are made: Provided, however, That the board may, in its discretion and upon inquiry as in cases of commutation, accelerate such payments.

(d) The provisions of the foregoing paragraph (c) shall not apply to employers who are exempted by the department from the necessity of carrying insurance.

(e) Possession of an employment certificate, duly issued and transmitted to the employer in accordance with the provisions of the child labor law, and receipt thereof duly acknowledged by him, shall be conclusive evidence to such employer of his legal right to employ the minor for whose employment such certificate has been issued.

(f) The possession of an age certificate, duly issued and transmitted to the employer by the school authorities of the school district in which a minor resides, shall be conclusive evidence to the employer of the minor's age as certified therein.

(g) If neither party has elected not to be bound by the provisions of article three of the act to which this act is an amendment, in the manner prescribed by section three hundred and two of said act, they shall be held to have agreed to be bound by the provisions of this act, and to have waived any other right or remedy at law or in equity, for the recovery of damages for injuries occurring under the circumstances herein described.

ARTICLE IV
Procedure

Sec 401 The term "employer," when used in this article, shall mean the employer as defined in article one of this act, or his duly authorized agent, or his insurer if such insurer has assumed the employer's liability, or the State Workmen's Insurance Fund of this Commonwealth if the employer be insured therein.

The department shall be deemed a "party in interest" in any proceeding under this article before a referee, the board or any court involving any claim for compensation, a part of which is payable by the Commonwealth under the provisions of this act.

Sec 403 (a) All proceedings before the board or any referee, and all appeals to the board, shall be instituted by petition addressed to the board. All petitions shall be in writing and in the form prescribed by the board.

(b) All petitions, all copies of agreements for compensation, and all papers requiring action by the board, shall be mailed or delivered to the department at its principal office.

Sec 404 The department shall, immediately upon their receipt, properly file and docket all petitions, agreements for compensation, findings of fact by the board or any referee, awards or disallowances of compensation, or modifications thereof, and all other reports or papers filed with it under the provisions of this act or the rules or regulations of the board.

Sec 405 Immediately upon receiving from the board or any referee any award or disallowance of compensation, or any modification thereof, or any other decision, the department shall serve a copy thereof on all parties in interest.

Sec 406 All notices and copies to which any party shall be entitled under the provisions of this article shall be served by mail, or in such manner as the board shall direct. For the purposes of this article any notice or copy shall be deemed served on the date when mailed, properly stamped and addressed, and shall be presumed to have reached the party to be served; but any party may show by competent evidence that any notice or copy was not received, or that there was an unusual or unreasonable delay in its transmission through the mails. In any such case proper allowance shall be made for the party's failure within the prescribed time to assert any right given him by this act.

The department, the secretary of the board, and every referee shall keep a careful record of the date of mailing every notice and copy required by this act to be served on the parties in interest.

Sec 407 On or after the seventh day after disability shall have begun or death shall have occurred, the employer and employe or his dependents may agree upon the compensation payable to the employe or his dependents under this act; but any agreement made prior to the seventh day after the disability shall have begun or the death shall have occurred, or permitting a commutation of payments contrary to the provisions of this act, or varying the amount to be paid or the period during which compensation shall be payable as provided in this act, shall be wholly null and void. It shall be unlawful for any employer to accept a receipt showing the payment of compensation when in fact no such payment has been made.

All agreements made in accordance with the provisions of this section shall be in writing, and signed by all parties in interest.

All agreements for compensation and all supplemental agreements for the modification, suspension, reinstatement, or termination thereof, and all receipts executed by any employe of whatever age, or by any dependent to whom compensation is payable under section three hundred and seven, and who has attained the age of sixteen years, shall be valid and binding unless modified or set aside as hereinafter provided.

Sec 408 All agreements for compensation may be modified, suspended, reinstated, or terminated at any time by a supplemental agreement approved by the department, if the disability of an employe has increased, decreased, recurred, or temporarily or finally terminated, or if the status of any dependent has changed.

Sec 409 Whenever an agreement or supplemental agreement shall be executed between an employer and employe or his dependents as provided by this act, such agreement shall be executed in triplicate. Two copies thereof, signed by all parties in interest, shall be mailed or delivered to the department within thirty days after execution. It shall be the duty of the department to examine the agreement to determine whether it conforms to the provisions of section four hundred and seven, to notify the parties thereto of its validity or invalidity, under the aforesaid section, within thirty days after the copies of the agreement have been mailed or delivered to it, and, if the agreement be approved, to send to the employe or dependents, together with such notification of its approval, a copy of the agreement: Provided, however, That any payment made in accordance with any agreement prior to the receipt of notice of invalidity shall discharge pro tanto the liability, under article three of this act, of the employer making such payments.

Sec 410 If, after any disability or death, the employer and the employe or his dependents shall fail to agree upon the facts thereof and the compensation due under this act, the employe or his dependents may present a claim for compensation to the board.

Whenever any claim for compensation is presented to the board, and is finally adjudicated in favor of the claimant, the amounts of compensation actually due at the time the first payment is made after such adjudication shall bear interest at the rate of six per centum per annum from the day such claim is presented, and such interest shall be payable to the same persons to whom the compensation is payable.

In case any claimant shall die before the final adjudication of his claim, the amount of compensation due such claimant to the date of death shall be paid to the dependents entitled to compensation, or, if there be no dependents, then to the estate of the decedent.

Sec 411 Whenever the employer and the employe or his dependent shall, on or after the seventh day after any disability begins or death occurs, agree on the facts on which a claim for compensation depends, but shall fail to agree on the compensation payable thereunder, they may petition the board to determine the compensation payable. Such petition shall contain the agreed facts, and shall be signed by all parties in interest. The board shall fix a time and place for hearing the petition, and shall notify all parties in interest. As soon as may be after such hearing, the board shall award or disallow compensation in accordance with the provisions of this act.

Sec 412 If any party shall desire the commutation of future installments of compensation, he shall present a petition therefor to the board.

Sec 413 The board, or a referee designated by the board, may, at any time, review and modify or set aside an existing original or existing supplemental agreement, upon petition filed by either party with the board or in the course of the proceedings under any petition pending before such board or referee, if it be proved that such agreement was in any material respect incorrect.

The board, or a referee designated by the board, may, at any time, modify, reinstate, suspend, or terminate an original or supplemental agreement or an award, upon petition filed by either party with such board, upon proof that the disability of the employe has increased, decreased, recurred, or has temporarily or finally ceased, or that the status of any dependent has changed. Such modification, reinstatement, suspension, or termination shall be made as of the date upon which it is shown that the disability of the employe has increased, decreased, recurred, or has temporarily or finally ceased, or upon which it is shown that the status of any dependent has changed: Provided, That an agreement or award can only be reviewed, or modified, or reinstated, during the time such agreement or award has to run, if for a definite period; and no agreement or award shall be reviewed, or modified, or reinstated, unless a petition is filed with the board within two years

after the date of the most recent payment of compensation made prior to the date of filing such petition. Where, however, a person is receiving benefits pursuant to the act of June 28, 1935 (P.L. 477, No. 193), referred to as the Heart and Lung Act, the two-year period in which a petition to review, modify, or reinstate a notice of compensation, agreement or award must be filed, shall not begin to run until the expiration of the receipt of benefits pursuant to said Heart and Lung Act. Where compensation has been suspended because the employe's earnings are equal to or in excess of his wages prior to the disability payments under the agreement or award may be resumed at any time during the period for which compensation for partial disability is payable, unless it be shown that the loss of earnings does not result from the disability due to the exposure.

The board or referee to whom any such petition has been assigned may subpoena witnesses, hear evidence, make findings of fact, and award, or disallow compensation in the same manner and with the same effect and subject to the same right of appeal, as if such petition were an original claim petition.

The filing of a petition to terminate or modify a compensation agreement or award as provided in this section shall operate as a supersedeas, and shall suspend the payment of compensation fixed in the agreement or by the award, in whole or to such extent as the facts alleged in the petition would if proved, require.

Sec 414 Whenever a claim petition or other petition is presented to the board, the board shall, by general rules or special order, either direct it to be heard by one or more members of the board or assign it to a referee for hearing: Provided, however, That petitions presented under sections four hundred and eleven and four hundred and twelve shall be heard by one or more members of the board.

The department shall serve upon each adverse party a copy of the petition, together with a notice that such petition will be heard by the board or the referee to whom it has been assigned (giving his name and address), as the case may be, and, if the petition shall have been assigned to a referee, shall mail the original petition to such referee, together with copies of the notices served upon the adverse parties.

Sec 415 At any time before an award or disallowance of compensation or order has been made by a referee to whom a petition has been assigned, the board may order such petition heard before it or one or more of its members or may reassign it to any other referee. Unless the board shall otherwise order, the testimony taken before the original referee shall be considered as though taken before the board or substituted referee.

Sec 416 Within twenty days after a copy of any petition has been served upon any adverse party, he may file with the secretary of the board if the petition has been directed to be heard by the board, or with the referee if the petition has been assigned to a referee, an answer in the form prescribed by the board.

Every fact alleged in a claim petition not specifically denied by an answer so filed by an adverse party shall be deemed to be admitted by him. But the failure of any adverse party, or of all of them, to deny a fact so alleged shall not preclude the board or referee before whom the petition is heard from requiring, of its or his own motion, proof of such fact.

Sec 417 As soon as may be after the twelfth day after notice that a petition has been directed to be heard by the board has been served upon the adverse parties thereto, the board shall fix a time and place for hearing the petition. If a petition be assigned to a referee, he shall, as soon as practicable thereafter, fix a time and a place for hearing the petition. The secretary of the board, if the petition has been directed to be heard by the board or by one or more of its members, or the referee to whom the petition has been assigned, shall serve upon all parties in interest a notice of the time and place of hearing, and shall serve upon the petitioner a copy of any answer of any adverse party.

Sec 418 The board, if a petition is directed to be heard by it or by one or more of its members, or the referee to whom a petition is assigned for hearing may subpoena witnesses, order the production of books and other writings, and hear evidence, and shall make, in writing and as soon as may be after the conclusion of the hearing, such

findings of fact, conclusions of law, and award or disallowance of compensation, or other order, as the petition and answers and the evidence produced before it or him and the provisions of this act shall, in its or his judgement, require. The findings of fact made by the board in any petition heard by it or by one or more of its members or upon a hearing de novo shall be final, except as hereinafter provided, and the findings of fact made by a referee to whom a petition has been assigned or any question of fact has been referred under the provisions of section four hundred and nineteen shall be final, unless an appeal is taken as provided in this act, or unless the board shall, under the provisions of sections four hundred and twenty-five or four hundred and twenty-six of this article, grant a hearing de novo or a rehearing.

Sec 419 The board may refer any question of fact arising under any petition, including a petition for commutation heard by it, to a referee to hear evidence and report to the board the testimony taken before him or such testimony and findings of facts thereon as the board may order. The board may refer any question of fact arising out of any petition assigned to a referee, to any other referee to hear evidence and report the testimony so taken thereon to the original referee.

Sec 420 The board or a referee, if it or he deem it necessary, may, of its or his own motion, either before, during, or after any hearing, make an investigation of the facts set forth in the petition or answer. The board or referee with the consent of the board, may appoint one or more impartial physicians or surgeons to examine the claimant and report thereon, or he may employ the services of such other experts as shall appear necessary to ascertain the facts. The report of any physician, surgeon, or expert appointed by the board or by a referee shall be filed with the board or referee, as the case may be, and shall be a part of the record and open to inspection as such.

The board shall fix the compensation of such physicians, surgeons, and experts, which, when so fixed, shall be paid out of the sum appropriated to the Department of Labor and Industry.

The sum of fifty thousand dollars ($50,000) is hereby appropriated to the Department of Labor and Industry for compensation payable by the Commonwealth under the provisions of this section for the biennium one thousand nine hundred fifty-five — one thousand nine hundred fifty-seven.

Sec 421 All hearings before the board or one or more members thereof, or before a referee, shall be public.

Sec 422 The board, its members and the referees shall not be bound by the technical rules of evidence in conducting hearings and investigations, but all findings of fact shall be based only upon sufficient, competent evidence to justify them.

If any party or witness resides outside of the Commonwealth, or through illness or other cause is unable to testify before the board or a referee, his or her testimony or deposition may be taken, within or without this Commonwealth, in such manner and in such form as the board may, by special order or general rule, prescribe. The records, kept by a hospital of the medical or surgical treatment given to an employe in such hospital, shall be admissible as evidence of the medical and surgical matters stated therein, but shall not be conclusive proof of such matters.

Where any claim for compensation at issue before a referee involves five weeks or less of disability, either the employe or the employer may submit a certificate by any qualified physician as to the history, examination, treatment, diagnosis and cause of the condition, and the statements shall be admissible as evidence of medical and surgical matters therein stated, but such statements and certificates shall not be admissible in any subsequent proceedings.

Where an employer has furnished surgical and medical services or hospitalization in accordance with the provisions of subsection (f) of section 306, or where the employe has himself procured them, the employer or employe shall, upon request, in any pending proceeding be furnished with or have made available a true and complete record of the medical and surgical services and hospital treatment, including X-rays, laboratory

tests, and all other medical and surgical data in the possession or under the control of the party requested to furnish or make available such data.

Sec 423 Any party in interest may, within twenty days after notice of a referee's award or disallowance of compensation shall have been served upon him, take an appeal to the board on the ground: (1) that the award or disallowance of compensation is not in conformity with the terms of this act, or that the referee committed any other error of law; (2) that the findings of fact and award or disallowance of compensation was unwarranted by sufficient, competent evidence, or was procured by fraud, coercion, or other improper conduct of any party in interest. The board may, upon cause shown, extend the time provided in this article for taking such appeal or for the filing of an answer or other pleading.

In any such appeal the board may disregard the findings of fact of the referee, and may examine the testimony taken before such referee, and if it deem proper may hear other evidence, and may substitute for the findings of the referee such findings of fact as the evidence taken before the referee and the board, as hereinbefore provided, may, in the judgment of the board, require, and may make such disallowance or award of compensation or other order as the facts so founded by it may require.

Sec 424 Whenever an appeal shall be based upon an alleged error of law, it shall be the duty of the board to grant a hearing thereon. The board shall fix a time and place for such hearing, and shall serve notice thereof on all parties in interest.

As soon as may be after such hearing, the board shall either sustain or reverse the referee's award or disallowance of compensation, or make such modification thereof as it shall deem proper.

Sec 425 Whenever an appeal shall be taken on the ground that the referee's award or disallowance of compensation was unwarranted by the evidence, or because of fraud, coercion, or other improper conduct by any party in interest, the board may, in its discretion, grant a hearing de novo before the board or one or more of its members, or assign the petition for rehearing to any referee designated by it, or sustain the referee's award or disallowance of compensation. If the board shall grant a hearing de novo, it shall fix a time and place therefor and notify all parties in interest.

As soon as may be after any hearing de novo by the board, it shall in writing state its findings of fact, and award or disallow compensation in accordance with the provisions of this act.

Sec 426 The board, upon petition of any party and upon cause shown, at any time before the court of common pleas of any county of this Commonwealth, to which an appeal has been taken under the provisions of section four hundred and twenty-seven of this article shall have taken final action thereon, may grant a rehearing of any petition upon which the board has made an award or disallowance of compensation or other order or ruling, or upon which the board has sustained or reversed any action of a referee; but such rehearing shall not be granted more than eighteen months after the board has made such award, disallowance, or order or ruling, or has sustained or reversed any action of the referee. If the board shall grant a rehearing of any petition from the board's action on which an appeal has been taken to and is pending in the court of common pleas under the provisions of section four hundred and twenty-seven of this article, the board shall file in such court a certified copy of its order granting such rehearing, and it shall thereupon be the duty of such court to cause the record of the case to be remitted to the board; Provided, however, That nothing contained in this section shall limit or restrict the right of the board, or a referee designated by the board, to review, modify, set aside, reinstate, suspend, or terminate, an original or supplemental agreement, or an award in accordance with the provisions of section four hundred thirteen of this article.

Sec 427 Any party may appeal from any action of the board on matters of law to the court of common pleas of the county in which the employe was last employed prior to his disability or death or of the county in which the adverse party resides or has a permanent place of business, or, by agreement of the parties, to the court of common pleas of any other county of this Commonwealth. The party taking the appeal shall, at the time of

taking the appeal, serve upon the adverse party a written notice thereof, setting forth the date of the appeal and the court in which the same is filed, and shall file, either with his notice of appeal, or within thirty days thereafter, such exceptions to the action of the board as he may desire to take, and shall specify the findings of fact, if any, of the board, or of the referee sustained by the board, which he alleges to be unsupported by sufficient, competent evidence.

Upon filing of the notice of an appeal, the prothonotary of the court of common pleas to which the appeal has been taken shall issue a writ of certiorari, directed to the board, commanding it, within ten days after service thereof, to certify to such court its entire record in the matter in which the appeal has been taken. The writ so issued shall be mailed by the prothonotary to the department at Harrisburg, together with a copy of the exceptions. The board shall, within ten days after such service, certify to such court its entire record in the matter in which the appeal has been taken, including the notes of testimony.

Any court before which an appeal is pending from any action of the board, may remit the record to the board for more specific findings of fact if the findings of the board or referee or of the medical board are not, in its opinion, sufficient to enable it to decide the question of law raised by the appeal.

If the court of common pleas shall affirm an award or order of the board or of a referee, sustained by the board, fixing the compensation payable under this act, the court shall enter judgment for the total amount stated by the award or order to be payable, whether then due and accrued or payable in future installments. If such court shall sustain the appellant's exceptions to a finding or findings of fact and reverse the action of the board founded thereon, the court shall remit the record to the board for further hearing and determination, in which the procedure shall be the same as that hereinbefore provided in this article in the case of a petition presented to the board, except that the testimony taken in the original proceedings shall be considered as though taken in such further hearing.

The prothonotary of any court of common pleas to which an appeal has been taken from the board, shall send to the board a certificate of the judgment of the court as soon as rendered, with a copy of any opinion which may be filed in the case, and, within five days, shall give notice of such judgment, and the date thereof, by registered mail to each attorney at law appearing in the case at the address given by the attorney in the pleadings, and, if no attorney at law has appeared by registered mail to the party or parties not represented by counsel. At the end of the period allowed for an appeal from the judgment of the court, the record of the board shall be remitted to it by the prothonotary unless an appeal shall have been taken. If such appeal shall be taken, the record shall be remitted to the board by the prothonotary on its return from the appellate court.

Sec 428 Whenever the employer, who has accepted and complied with the provisions of section three hundred five, shall be in default in compensation payments for thirty days or more, the employe or dependents entitled to compensation thereunder may file a certified copy of the agreement and the order of the board approving the same, or of the award or order, with the prothonotary of the court of common pleas of any county, and the prothonotary shall enter the entire balance payable under the agreement, award or order to be payable to the employe or his dependents, as a judgment against the employer or other party liable under such agreement or award. Where the compensation so payable is for a total and permanent disability, the judgment shall be in the amount of thirty thousand dollars less such amount as the employer shall have actually paid pursuant to such agreement or award. Such judgment shall be a lien against property of the employer or other party liable under such agreement or award, and execution may issue thereon forthwith.

Wherever, after disability or death, any employe or his dependents shall have entered into a compensation agreement with an employer liable for compensation under this act, who has not accepted or complied with the provisions of section three hundred five, or shall file a claim petition against such employer, he may file a certified copy thereof with the prothonotary of the court of common pleas of any county. The prothonotary shall enter the amount stipulated in any such agreement or claimed in any such petition as judgment against the employer, and where the amount so stipulated or claimed is for total disability, such judgment shall be in the sum of thirty thousand dollars. If the agreement be approved by the department, or compensation

awarded as claimed in the petition, the amount of compensation stipulated in the agreement or claimed in the petition shall be a lien, as of the date when the agreement or petition was filed with the prothonotary. Pending the approval of the agreement or the award of compensation, no other lien which may be attached to the employer's property during such time shall gain priority over the lien of such agreement or award, but no execution shall issue on any compensation judgment before the approval of the agreement or the award of compensation on the said petition.

If the agreement be disapproved, or, after hearing, compensation shall be disallowed, the employer may file, with the prothonotary of any county in which the petition or agreement is on record as a judgment, a certified copy of the disapproval of the agreement or disallowance of compensation, and it shall be the duty of such prothonotary to strike off the judgment.

If the amount of compensation claimed be disallowed, but another amount awarded, the compensation judgment shall be a lien to the extent of the award, as of the date of filing the petition with the prothonotary, with the same effect as to other liens and the same disability to issue execution thereon as if the compensation claimed had been allowed. In such cases the prothonotary shall make such modification of the record as shall be appropriate.

If the compensation payable under any agreement or award upon which judgment has been entered under the provisions of this section shall be modified, suspended, reinstated, or terminated by a supplemental agreement executed under the provisions of section four hundred and eight, or by an award or order made under the provisions of section four hundred and thirteen, any party to such judgment, at any time after such agreement has been approved by the department or after the expiration of the time allowed for an appeal from the award or order, may file with the prothonotary of the court of common pleas of any county in which the judgment is on record a certified copy of such supplemental agreement, award, or order, and it shall thereupon be the duty of the prothonotary to modify, suspend, reinstate, or satisfy such judgment in accordance with the terms of such supplemental agreement, award or order.

Execution may issue by first filing with the prothonotary an affidavit that there has been a default in payments of compensation due on any judgment for compensation, entered prior to the approval of the compensation agreement, or an award on petition, as soon as such agreement shall have been approved by the department, or such award made as evidenced by the approval of the board of the award or by a certified copy thereof.

Execution shall in all cases be for the amount of compensation and interest thereon due and payable up to the date of the issuance of said execution, with costs, and further execution may issue from time to time as further compensation shall become due and payable, until full amount of the judgment with costs shall have actually been paid.

Sec 429 If any party against whom a compensation agreement, award, or other order fixing the compensation payable under this act has been filed of record in any county of this Commonwealth in accordance with the provisions of section four hundred and twenty-eight of this article, or against whom judgment has been entered by the prothonotary of the court of common pleas of any county on any award or order of the board or a referee, shall, at any time, present to the board receipts or copies thereof, certified by any referee, showing the payment of compensation as required by the agreement or award in full to the date of presentation to the referee, the board shall issue a certificate to such party, in the form prescribed, stating the extent to which the judgment on the agreement or award has been reduced. Upon the presentation of such certificate to the prothonotary of the court of common pleas of any county in which such agreement or award has been filed of record as a judgment, or in which judgment on an award has been entered by the prothonotary of the court of common pleas, it shall be the prothonotary’s duty to mark such judgment satisfied to the extent of the payments so certified, and, upon the presentation to such prothonotary of a certificate issued by the board under the provisions of section three hundred and seventeen of this act, it shall be the duty of the prothonotary to mark such judgment fully satisfied.

Sec 430 The lien of any judgment entered upon any award shall not be divested by any appeal. If, however, the party appealing from the award shall file with the board a bond, in such amount and in such form as the rules and regulations of the board shall direct, the appeal shall, pending its decision, excuse the payment of so much of the compensation as is contested therein; but if the final decision on appeal shall sustain the award, it shall be the duty of the employer by whom such award is payable to make payments of compensation as from the date of the original award. If on appeal the award is sustained as to a part, it shall be the duty of the employer by whom such part is payable to make payments as from the date of the original award. In case the award is annulled on appeal, it shall be the duty of the prothonotary of any county in which such award has been entered as a judgment to mark it satisfied.

Sec 431 The cost of the prothonotary for entering the amount of compensation as provided in this act, or making a modification of the record, or marking the judgment satisfied, shall be allowed, taxed, and collected as upon a confession of judgment on a judgment note.

Sec 434 A final receipt, given by an employe or dependent entitled to compensation under a compensation agreement or award, shall be prima facie evidence of the termination of the employer's liability to pay compensation under such agreement or award: Provided, however, That the board, or a referee designated by the board, may, at any time within two years from the date to which payments have been made, set aside a final receipt, upon petition filed with the board, if it be conclusively proved that all disability due to the occupational disease in fact had not terminated. Where, however, a person is receiving benefits pursuant to the act of June 28, 1935 (P.L. 477, No. 193), referred to as the Heart and Lung Act, the two-year period within which the board or a referee designated by the board may set aside a final receipt upon petition filed with the board, shall not begin to run until the expiration of receipt of benefits under the Heart and Lung Act.

ARTICLE V
General Provisions

Sec 501 No claim or agreement for legal services or disbursements in support of any demand made or suit brought under the provisions of article two of this act shall be an enforceable lien against the amount to be paid as damages, or be valid or binding in any respect, unless the same be approved in writing by the judge presiding at the trial, or, in case of settlement without trial, by a judge of the common pleas court of the county in which the accident occurred.

No claim or agreement for legal services or disbursements in support of any claim for compensation, or in preparing any agreement for compensation, under article three of this act, shall be an enforceable lien against the amount to be paid as compensation, or be valid or binding in any other respect, unless the same be approved by the board. Any such claim or agreement shall be filed with the department, which shall, as soon as may be, notify the person by whom the same was filed of the board's approval or disapproval thereof, as the case may be.

After the approval as herein required if the employer be notified in writing of such claim or agreement for legal services and disbursements, the same shall be a lien against any amount thereafter to be paid as damages or compensation: Provided, however, That where the employe's compensation is payable by the employer in periodical installments, the board shall fix, at the time of approval, the proportion of each installment to be paid on account of legal services and disbursements, and the board may, upon application made to it, commute the sum awarded for legal services and disbursements.

Sec 501.1 Any person who solicits money for assisting any person to obtain any benefits under this act shall be guilty of a misdemeanor and upon conviction thereof shall be sentenced to pay a fine not to exceed One Thousand Dollars ($1,000) and costs of prosecution, or to undergo imprisonment for one year, or both. This provision shall not apply to an attorney at law who for a fee has been retained by a claimant to give him legal advice and assistance in obtaining benefits.

Sec 502 Nothing in this act shall affect or impair any rights of action which have accrued before this act shall take effect.

Sec 503 If any provision of this act shall be held by any court to be unconstitutional, such judgment shall not affect any other section or provision of this act, except that articles two and three are hereby declared to be inseparable and as one legislative thought, and if either article be declared by such court void or inoperative in an essential part so that the whole of such article must fall, the other article shall fall with it and not stand alone.

Sec 504 The following acts are hereby specifically repealed: The act, approved the second day of July, one thousand, nine hundred thirty-seven (Pamphlet Laws, twenty seven hundred fourteen), entitled "A supplement to the act, approved the second day of June, one thousand nine hundred fifteen (Pamphlet Laws, seven hundred thirty-six), entitled, as amended 'An act defining the liability of an employer to pay damages for injuries received by an employe in the course of employment; establishing a system and schedule of compensation; providing procedure for the determination of liability and compensation thereunder; and prescribing penalties,' as amended and reenacted, providing for the inclusion of occupational diseases within the scope thereof, and providing definitions, provisions, and procedure related to such disease; and making an appropriation."

All other acts and parts of act inconsistent with the provisions of this act.

Sec 505 The provisions of this act shall become effective on October first, one thousand nine hundred and thirty-nine, except the provisions of section three hundred two of this act, which shall become effective immediately upon the final enactment of this act.

Rules and Regulations

TITLE 34. LABOR AND INDUSTRY

PART VII. WORKERS' COMPENSATION APPEAL BOARD

CHAPTER 111. SPECIAL RULES OF ADMINISTRATIVE PRACTICE AND PROCEDURE BEFORE THE WORKERS' COMPENSATION APPEAL BOARD

SUBCHAPTER A. GENERAL PROVISIONS

§ 111.1. Scope

(a) This chapter applies to proceedings before the Board under the act and the Disease Law.

(b) Subsection (a) supersedes 1 Pa. Code § 31.1 (relating to scope of part).

§ 111.2. Applicability of General Rules of Administrative Practice and Procedure

(a) This chapter is intended to supersede 1 Pa. Code Part II (relating to General Rules of Administrative Practice and Procedure). The General Rules of Administrative Practice and Procedure are not applicable to activities of and proceedings before the Board.

(b) Subsection (a) supersedes 1 Pa. Code § 31.4 (relating to information and special instructions).

§ 111.3. Definitions

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

Act — The Workers' Compensation Act (77 P. S. §§ 1 — 1041.4 and 2501 — 2708).

Appeal — A proceeding to review a ruling or decision by a judge.

Board — The Workers' Compensation Appeal Board.

Disease Law — The Pennsylvania Occupational Disease Act (77 P. S. §§ 1201 — 1603).

Filing — Filing is deemed complete upon one of the following:

(i) Delivery in person.

(ii) If by electronic submission, upon receipt and in a format as prescribed by the Department and published in the *Pennsylvania Bulletin* or the Department's web site located at www.dli.state.pa.us.

(iii) If by mail, upon deposit in the United States mail, properly addressed, postage or charges prepaid, as evidenced by one of the following:

(A) United States Postal Service postmark.

(B) United States Postal Service Certificate of Mailing (USPS Form 3817 or other similar United States Postal Service form from which the date of deposit can be verified), enclosed with the filing or submitted separately to the Department.

(iv) An appeal may be delivered by a common carrier of property which is subject to the authority of the Pennsylvania Public Utility Commission or the United States National Surface Transportation Board. The date of filing is the date the document was delivered to the common carrier, as established by a document or other record prepared by the common carrier in the normal course of business. If the date of delivery to the common carrier cannot be determined by the documents in the record, the date of filing will be the date of its receipt by the Board.

Judge — A workers' compensation judge assigned by the Office of Adjudication as provided in section 401 of the act (77 P. S. § 701) or assigned by the Office of Adjudication to determine a petition filed under the Disease Law.

Office of Adjudication — The Office of the Department created under section 1401(a) of the act (77 P. S. § 2501(a)).

Party — A petitioner or respondent. An act required or authorized by this chapter, to be done by or to a party, may be done by or to that party's counsel of record.

Petitioner — Anyone seeking to review a ruling or decision by a judge or the moving party in a petition filed under Subchapter D (relating to other petitions).

Respondent — Anyone in whose favor the matter was decided by the judge or other than the moving party in any petition filed under Subchapter D.

Service — Delivery in person, by mail or electronics. If service is by mail, it is deemed complete upon deposit in the United States mail, as evidenced by a United States Postal Service postmark, properly addressed, with postage or charges prepaid.

Supersedeas — A temporary stay affecting a workers' compensation case.

(b) Subsection (a) supersedes 1 Pa. Code §§ 31.3, 31.11 and 33.34 (relating to definitions; timely filing required; and date of service).

SUBCHAPTER B. APPEALS

§ 111.11. Content and form

(a) An appeal or cross appeal shall be filed with the Board on a form provided by the Board. All references to forms mean paper forms or an electronic format prescribed by the Board and published in the *Pennsylvania Bulletin* or the Department's web site located at www.dli.state.pa.us. All forms must contain the following information:

(1) The name and address of the claimant, name and address of the defendant, date of the injury, type of petition, insurance carrier and circulation date of the decision at issue. An appeal from a workers' compensation judge's decision is deemed to include all claim numbers, dispute numbers and petition numbers referenced in the decision and order which are the subject of the appeal. This paragraph does not supersede the other requirements of this section.

(2) A statement of the particular grounds upon which the appeal is based, including reference to the specific findings of fact which are challenged and the errors of the law which are alleged. General allegations which do not specifically bring to the attention of the Board the issues decided are insufficient.

(3) A statement of the relief which is requested.

(4) A statement whether the petitioner seeks an opportunity to file a brief or present oral argument or whether the case should be heard on the record without brief or oral argument.

(5) Identification of the judge whose decision is in question, including as an attachment, a copy of that judge's decision.

(6) A proof of service as specified in § 111.12(e) (relating to filing, service and proof of service).

(b) An appeal or a cross appeal shall be served on all parties and the judge.

(c) A request for supersedeas, if desired, shall be indicated on the appeal and conform to § 111.21 (relating to content and form).

(d) Subsections (a) — (c) supersede 1 Pa. Code §§ 31.5, 33.1 — 33.4, 33.11, 33.12, 35.17 and 35.20.

§ 111.12. Filing, service and proof of service

(a) When filing other than electronically, an original of each appeal or cross appeal shall be filed. The appeal shall have attached a copy of the judge's decision which is in question as required by § 111.11(a)(5) (relating to content and form).

(b) When filing electronically, the petitioner shall follow the online procedures established by the Department on its web site located at www.dli.state.pa.us.

(c) The petitioner shall serve a copy of any appeal upon all parties and the judge.

(d) The respondent shall serve a copy of any cross appeal upon all parties and the judge.

(e) The petitioner or respondent shall, concurrently with the filing of an appeal or cross appeal, on a form prescribed by the Board or in substantial compliance therewith, file a proof of service with the Board containing:

(1) A statement of the date of service.

(2) The names of parties and judge served.

(3) The mailing address, the applicable zip code and the manner of service on the parties and judge served.

(f) Subsections (a) — (e) supersede 1 Pa. Code §§ 31.26, 33.15, 33.32, 33.33 and 33.35 — 33.37.

§ 111.13. Processing of appeals and cross appeals

(a) Upon receipt of an appeal or a cross appeal, the Board will acknowledge receipt to all parties.

(b) The Board will, in addition to acknowledging receipt of the appeal or the cross appeal, establish the briefing schedule and indicate that the appeal and the cross appeal will be scheduled for oral argument unless all parties agree to submission of the case on only briefs or record.

(c) Subsections (a) and (b) supersede 1 Pa. Code § 33.31 (relating to service by the agency).

§ 111.14. Motions to quash

(a) A party may submit a motion to quash an appeal or a cross appeal within 20 days of service of the appeal or the cross appeal.

(b) A motion to quash shall be served on all parties.

(c) A motion to quash shall be accompanied by a proof of service conforming to § 111.12(e) (relating to filing, service and proof of service), insofar as applicable.

(d) The Board shall dispose of a motion to quash in conformity with the procedures set forth in § 111.35 (relating to dispositions of petitions).

(e) An original motion to quash shall be filed.

(f) Subsections (a) — (e) supersede 1 Pa. Code §§ 31.26, 33.15, 33.32, 33.33, 33.35 — 33.37, 35.54 and 35.55 and also supersede 1 Pa. Code Chapter 35, Subchapter D (relating to motions).

§ 111.15. No other pleadings allowed

(a) Other than a motion to quash as set forth in § 111.14 (relating to motions to quash) and a cross-appeal, as set forth in § 111.11 (relating to content and form), no answer or other pleading may be filed or considered in conjunction with an appeal or a cross appeal.

(b) Subsection (a) supersedes 1 Pa. Code §§ 31.24, 31.25, 33.41, 33.42, 33.61, 35.1, 35.2, 35.5 — 35.7, 35.9 — 35.11, 35.14, 35.18, 35.19, 35.23, 35.24, 35.27 — 35.30, 35.35 — 35.41, 35.48 — 35.51, 35.54, 35.55, 35.211, 35.213, 35.231, 35.241 and 35.251.

§ 111.16. Briefs: content and form and time for filing

(a) A brief on behalf of a petitioner shall be filed with the Board at or before the date of oral argument. If oral argument is waived, petitioner shall file a brief within 30 days of the date of the Board's acknowledgment of receipt of the appeal as set forth in § 111.13 (relating to processing of appeals and cross appeals).

(b) A brief on behalf of a respondent shall be filed with the Board 30 days after oral argument. Otherwise, the respondent shall file a brief with the Board within 60 days of the date of the Board's acknowledgment of receipt of the appeal as set forth in § 111.13.

(c) Upon written request of a party directed to the Secretary of the Board or upon oral request at the time of oral argument, and with notice to all parties, the Board may extend or shorten the time for filing of the party's brief only for good cause shown. A party shall present a request to extend or shorten the time at or before the date set for filing that party's brief.

(d) Briefs not filed with the Board in accordance with the schedule in this section or as modified by the Board under subsection (c) will not be considered and will result in disposition of the appeal without further notice or consideration of the brief of the party failing to comply with these deadlines or schedule.

(e) Briefs, except as otherwise allowed, shall consist of the following items, separately and distinctly set forth:

(1) A short statement of the questions involved.

(2) A statement of the facts by the petitioner, or counterstatement of the facts by the respondent.

(3) The argument.

(4) A short conclusion setting forth the precise relief sought.

(5) A proof of service as specified in § 111.12(e) (relating to filing, service and proof of service) insofar as applicable.

(f) An original brief shall be filed.

(g) Briefs shall be served on all parties.

(h) Subsections (a) — (g) supersede 1 Pa. Code §§ 31.15, 33.37, 35.212 and 35.221 and also supersede 1 Pa. Code Chapter 35, Subchapter F (relating to briefs).

§ 111.17. Oral argument

(a) The Board will schedule oral argument in every appeal or cross appeal unless all parties to the appeal or the cross appeal, upon receiving the acknowledgment of appeal or cross appeal, indicate that no oral argument is requested, or that it is waived.

(b) The Board will hear oral argument on appeals and cross appeals according to a schedule prepared in advance for each calendar year. Oral argument will be conducted in Harrisburg, Philadelphia and Pittsburgh and in other locations throughout this Commonwealth, as the Board may schedule, or, as is appropriate in the Board's judgment.

(c) Oral argument will be scheduled at the earliest possible date pursuant to the schedule as established by the Secretary of the Board.

(d) Parties shall be advised as far in advance as possible of the date of oral argument by the acknowledgment of appeal or cross appeal as specified in § 111.13(b) (relating to processing of appeals and cross appeals).

(e) Oral argument shall consist of a presentation, including rebuttal, if necessary, by the petitioner and respondent.

(f) A petitioner or respondent represented by counsel need not be present at oral argument.

(g) Oral argument may be conducted before one or more members of the Board.

(h) Subsections (a) — (g) supersede 1 Pa. Code §§ 33.51, 35.204, 35.214 and 35.221.

§ 111.18. Decisions of the Board

(a) The decision of the Board on an appeal and a cross appeal shall be issued as promptly as possible following oral argument or the receipt of briefs, whichever occurs later.

(b) Decisions of the Board on an appeal shall be issued under section 441 of The Administrative Code of 1929 (71 P. S. § 151).

(c) Decisions of the Board will be served on all parties and the judge from whose decision the appeal was taken.

(d) Subsections (a) — (c) supersede 1 Pa. Code §§ 31.13, 31.14, 35.201 — 35.207 and 35.226.

SUBCHAPTER C. SUPERSEDEAS ON APPEAL TO THE BOARD AND COURTS

§ 111.21. Content and form

(a) A request for supersedeas shall be filed as a separate petition from the appeal and be accompanied by the following:

(1) A copy of the decision and order of the judge or order and opinion of the Board from which the supersedeas is requested.

(2) A short statement setting forth reasons and bases for the request for supersedeas.

(3) A specific statement as to the issues of law, if any, involved in the underlying appeal.

(4) Information on the current employment status of the claimant, if known.

(5) The court, if any, to which an appeal from the Board decision has been taken.

(6) Other relevant information for the Board's consideration in determining whether the supersedeas request meets the following standards:

(i) The petitioner makes a strong showing that it is likely to prevail on the merits.

(ii) The petitioner shows that, without the requested relief, it will suffer irreparable injury.

(iii) The issuance of a stay will not substantially harm other interested parties in the proceeding.

(iv) The issuance of a stay will not adversely affect the public interest.

(7) A proof of service as specified in § 111.12(e) (relating to filing, service and proof of service), insofar as applicable.

(b) Requests for supersedeas shall be served on all parties.

(c) Subsections (a) and (b) supersede 1 Pa. Code §§ 35.1, 35.2, 35.17, 35.190 and 35.225.

§ 111.22. Filing

(a) A request for supersedeas from the judge's decision shall be filed with the Board within the time specified in section 423 of the act (77 P. S. § 853).

(b) A request for supersedeas from a Board order shall be filed under the applicable Pennsylvania Rules of Appellate Procedure.

(c) An original request for supersedeas shall be filed. The supersedeas request shall have attached a copy of the judge's decision and order or Board opinion and order from which the supersedeas is requested.

(d) A request for supersedeas shall be served on all the parties and be accompanied by a proof of service as specified in § 111.12(e) (relating to filing, service and proof of service).

(e) Subsections (a) — (d) supersede 1 Pa. Code § 33.15 (relating to number of copies).

§ 111.23. Answers

(a) An answer to a request for supersedeas may be filed with the Board within 10 days of service of the request for supersedeas.

(b) An original answer shall be filed.

(c) An answer filed under this subsection shall be served on all parties.

(d) An answer filed under this subsection shall be accompanied by a proof of service as specified in § 111.12(e) (relating to filing, service and proof of service), insofar as applicable.

(e) Subsections (a) — (d) supersede 1 Pa. Code §§ 33.15 and 35.35 (relating to number of copies; and answers to complaints and petitions).

§ 111.24. Disposition of request for supersedeas

(a) The Board may grant the request for supersedeas in whole or in part.

(b) The Board will rule on requests for supersedeas within 30 days of the date of receipt by the Board of the request, or the request shall be deemed denied.

(c) Subsections (a) and (b) supersede 1 Pa. Code §§ 35.190 and 35.225 (relating to appeals to agency head from rulings of presiding officers; and interlocutory orders).

§ 111.25. — 111.30 [Reserved]

SUBCHAPTER D. OTHER PETITIONS

§ 111.31. Applicability

This subchapter applies to the following petitions or requests:

(1) A petition under section 306 of the act (77 P. S. § 513).

(2) A petition for appointment of guardian under section 307 of the act (77 P. S. § 542).

(3) A petition alleging a meretricious relationship under section 307 of the act (77 P. S. § 562).

(4) A petition for commutation under section 316 of the act (77 P. S. § 604).

(5) A petition under section 317 of the act (77 P. S. § 603).

(6) A petition for rehearing or reconsideration under section 426 of the act (77 P. S. § 871).

(7) A petition for attorney's fees under section 442 or 501 of the act (77 P. S. §§ 998 and 1021).

§ 111.32. Form/content

(a) Petitions and requests shall contain and be accompanied by the following:

(1) A short statement setting forth the reasons and basis for the petition or request.

(2) The facts upon which the petition or request is based.

(3) A specific statement as to the issues of law, if any, involved in the petition or request.

(4) An explanation as to the status of the case, including the status of a pending appeal or petition before a judge, the Board or a court.

(5) The employment status of the claimant.

(6) A proof of service as specified in § 111.12(e) (relating to filing, service and proof of service), insofar as applicable.

(b) Petitions and requests shall be served on all parties and on the judge if the case is pending before a judge.

(c) An original petition and request shall be filed.

(d) Subsections (a) — (c) supersede 1 Pa. Code §§ 31.5, 33.1 — 33.4, 33.11, 33.12, 33.15, 33.21 — 33.23, 35.1, 35.2 and 35.17.

§ 111.33. Specific petitions/requirements

(a) A petition for commutation under section 316 of the act (77 P. S. § 604), in addition to the information required by § 111.32(a) (relating to form/content), shall have attached to it:

(1) The decision or document evidencing the employer/insurer's or self-insurer's responsibility to make current workers' compensation payments.

(2) The affidavit of the claimant, stipulation or other agreement signed by the parties which, if approved, will form the basis of the proposed commutation.

(3) An original and one copy of an order to be made by the Board if the commutation is approved.

(b) A petition under section 317 of the act (77 P. S. § 603), in addition to the information required by § 111.32(a), shall have attached to it:

(1) The document or agreement evidencing the annuity or trust.

(2) The stipulation or agreement, if any, entered into by the party which, if approved, would form the basis of the approval of the annuity or trust.

(3) An original and one copy of an order to be made by the Board if the annuity or trust is approved.

(c) Subsections (a) and (b) supersede 1 Pa. Code §§ 33.15, 35.17 and 35.155 (relating to number of copies; petitions generally; and presentation and effect of stipulations).

§ 111.34. Answers to Petitions

(a) An answer to a petition or request may be filed with the Board within 20 days of service of the petition or request.

(b) An original answer shall be filed.

(c) An answer filed shall be served on all parties.

(d) An answer filed shall be accompanied by a proof of service as specified in § 111.12(e) (relating to filing, service and proof of service), insofar as applicable.

(e) Subsections (a) — (d) supersede 1 Pa. Code §§ 33.15 and 35.35 (relating to number of copies; and answers to complaints and petitions).

§ 111.35. Dispositions of petitions

(a) The Board will allow and consider briefs which are submitted simultaneously with the petition or request or answer thereto. A brief which is not submitted simultaneously with the petition, request or answer thereto, will not be considered by the Board and the petition or request may be determined on the petition or request and answer thereto without further argument or brief.

(b) A brief submitted with a petition, request or answer thereto shall conform to the requirements of § 111.16(e) — (g) (relating to briefs: content and form and time for filing).

(c) Oral argument on a petition may be scheduled at the discretion of the Board. Parties will be notified of the scheduling of oral argument as far in advance of the argument date as possible. The scheduling and conduct of oral argument will conform to the requirements of § 111.17 (relating to oral argument).

(d) The Board may, if appropriate, or will, if required by law, refer a petition or request to a judge for conducting hearings, preparing findings or proposed orders. Thereafter, the petition or request shall, if appropriate or required, be returned to the Board.

(e) Subsections (a) — (d) supersede 1 Pa. Code Chapter 35, Subchapters B, C, E and I.

§ 111.41. [Reserved]

§ 111.42. [Reserved]

§ 111.43. [Reserved]

§ 111.44. [Reserved]

TITLE 34. LABOR AND INDUSTRY

PART VIII. BUREAU OF WORKERS' COMPENSATION

CHAPTER 121. GENERAL PROVISIONS

§ 121.1. Definitions

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

Act — The Workers' Compensation Act (77. P. S. §§ 1 — 1041.4 and 2501 — 2506).

Agreement — For purposes of this chapter, an agreement is limited to any of the following:

(i) Agreement for Compensation for Disability or Permanent Injury, Form LIBC-336.

(ii) Supplemental Agreement for Compensation for Disability or Permanent Injury, Form LIBC-337.

(iii) Agreement for Compensation for Death, Form LIBC-338.

(iv) Supplemental Agreement for Compensation for Death, Form LIBC-339.

Approved rating organization — One or more organizations situated within this Commonwealth, subject to supervision and to examination by the Insurance Commissioner and approved by the Insurance Commissioner as adequately equipped to perform the functions specified in Article VII of the act (77 P. S. §§ 1035.1—1035.22) on an equitable and impartial basis.

Board — The Workers' Compensation Appeal Board.

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

Claimant — An individual who files a petition for, or otherwise receives, benefits under the act or the Disease Law.

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

Disease Law — The Occupational Disease Act (77 P. S. §§ 1201 — 1603).

Earned premium — A direct premium earned as required to be reported to the Insurance Department on Special Schedule "W," under section 655 of The Insurance Company Law of 1921 (40 P. S. § 815). For the purposes of this chapter, direct premium earned may not include:

(i) The effects of premium credits granted under deductible elections by insured employer.

(ii) Premiums not attributable to coverage under the act or the Disease Law.

(iii) Premiums attributable to excess policies written for specified retentions on self-insured employers.

Employer — As defined in section 401 of the act (77 P. S. § 701), including the insurer and a self-insured employer.

First report of injury — A filing made with the Bureau under section 438 of the act (77 P. S. § 994).

Insurance carrier — An entity or group of affiliated entities subject to The Insurance Company Law of 1921 (40 P. S. §§ 341 — 477d), including the State Workers' Insurance Fund, but not including self-insured employers or runoff self-insurers, with which an employer has insured its liability under section 305 of the act (77 P. S. § 501).

Insured employer — An employer which has chosen to insure its workers' compensation liabilities through a workers' compensation insurance carrier licensed to do so in this Commonwealth, including the State Workers' Insurance Fund.

Insurer —

(i) A workers' compensation insurance carrier which is licensed to insure workers' compensation liabilities in this Commonwealth and acts in this capacity on behalf of insured employers.

(ii) The term includes a self-insured employer and a runoff self-insurer.

Runoff self-insurer — An employer that had been a self-insurer but no longer maintains a current permit to self-insure under section 305 of the act (77 P. S. § 501).

Self-insured employer —

(i) An employer which has been granted the privilege to self-insure its liability under the act.

(ii) The term includes a parent company or affiliate which has assumed a subsidiary's or an affiliate's liability upon the termination of the parent-subsidiary or affiliate relationship, and a runoff self-insurer.

Special funds — Funds maintained under sections 306.2, 443 and 446 of the act (77 P. S. §§ 517, 999 and 1000.2).

§ 121.2. [Reserved]

§ 121.3. Filing of forms

(a) Forms must be in the format prescribed by the Bureau. All references to forms mean paper forms or an electronic format prescribed by the Bureau.

(b) The Bureau may return forms that are not properly completed or filed. If a form is returned, the Bureau will notify the submitting party as to the reason the form was returned. For a form returned for the first time, the Bureau will preserve the filing date if the submitting party files a corrected version of the form within 14 days of the written notice of the return of the form.

(c) The filing date is the date indicated on the United States Postal Service postmark or postal receipt. If the postmark or postal receipt is absent or unreadable, the filing date is the date of receipt by the Bureau. In all other instances, including electronic filing or hand-delivery, the filing date is the Bureau's date of receipt.

§ 121.3a. Computation of time

Except as otherwise provided by law, in computing a period of time prescribed or allowed by this chapter, the day of the act, event or default after which the designated period of time begins to run may not be

included. The last day of the period so computed shall be included, unless it is Saturday, Sunday or a legal holiday in this Commonwealth, in which event the period shall run until the end of the next day which is neither a Saturday, Sunday nor a holiday. A part-day holiday shall be considered as other days and not as a holiday. Intermediate Saturdays, Sundays and holidays shall be included in the computation.

§ 121.3b. Providing workers' compensation information

(a) The workers' compensation information specified in subsection (b) shall be provided to every employee at the time of hire 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, the information shall be given as soon after the occurrence of the injury as is practicable.

(b) The information shall be entitled "Workers' Compensation Information" and include the following:

(1) The workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

(2) Benefits are required to be paid by your employer when self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employees or for the administration of first aid.

(3) You should report immediately any injury or work-related illness to your employer.

(4) Your benefits could be delayed or denied if you do not notify your employer immediately.

(5) If your claim is denied by your employer, you have the right to request a hearing before a workers' compensation judge.

(6) The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information at: Bureau of Workers' Compensation, 1171 South Cameron Street, Room 103, Harrisburg, Pennsylvania 17104-2501; telephone number within Pennsylvania (800) 482-2383; telephone number outside of this Commonwealth (717) 772-4447; TTY (800) 362-4228 (for hearing and speech impaired only); www.dli.state.pa.us, keyword: workers comp.

(c) The information specified in subsection (b) must be printed on paper no smaller than 8 ½ x 11 inches and in font no smaller than 11 point.

§ 121.4. [Reserved]

§ 121.5. Reporting injuries to the bureau

(a) The employer shall file a first report of injury as follows:

(1) Within 48 hours for every injury resulting in death.

(2) Within 7 days after the date disability begins for all other injuries covered by section 438 of the act (77 P. S. § 994).

(3) If there is no disability, a copy of the report should not be sent to the Department.

(b) The employer shall send a copy of the first report of injury to the employee simultaneously with filing it with the Bureau.

(c) A disability that requires a first report of injury is defined as an injury only resulting in death or disability continuing the entire day, shift or turn, or longer, in which the injury was received.

§ 121.6. [Reserved]

§ 121.7. Notice of compensation payable

(a) If an employer files a Notice of Compensation Payable, Form LIBC-495, the employer shall do all of the following simultaneously and no later than 21 days from the date the employer had notice or knowledge of the disability:

(1) Send the Notice of Compensation Payable, Form LIBC-495, to the employee or the employee's dependent.

(2) Pay compensation to the employee or to the employee's dependent.

(3) File the Notice of Compensation Payable, Form LIBC-495, with the Bureau.

(b) A Statement of Wages, Form LIBC-494A, or Statement of Wages, Form LIBC-494C, shall be filed with every Notice of Compensation Payable, Form LIBC-495, except a Statement of Wages, Form LIBC-494A, or Statement of Wages, Form LIBC-494C, may not be filed with either of the following:

(1) An estimated Notice of Compensation Payable, Form LIBC-495, filed under subsection (c).

(2) A Notice of Compensation Payable, Form LIBC-495, filed under subsection (e).

(c) The employer may file a Notice of Compensation Payable, Form LIBC-495, based upon the employee's estimated wages if the employer has not obtained the wages necessary to properly calculate the employee's compensation payable. The estimated Notice of Compensation Payable, Form LIBC-495, shall be clearly identified as "Estimated."

(d) If the estimated wages or compensation is not correct, the employer shall amend the estimated Notice of Compensation Payable, Form LIBC-495, upon receipt of the employee's actual wages in one of the following ways:

(1) Amendments resulting in an increase in the employee's wage or compensation shall be filed with the Bureau under § 121.12 (relating to Bureau review of agreements and notices of compensation payable), and shall be clearly identified as "Amended" and may have only the insurer's signature.

(2) The employer shall file a Supplemental Agreement for Compensation for Disability or Permanent Injury, Form LIBC-337, under § 121.17 (relating to change in compensation) when there are changes resulting in a decrease in the employee's wage or compensation.

(e) In medical only cases, when an employee's injury has not resulted in lost time from work, an employer may file a Notice of Compensation Payable, Form LIBC-495.

§ 121.7a. Notice of temporary compensation payable

(a) If an employer files a Notice of Temporary Compensation Payable, Form LIBC-501, the employer shall do all of the following simultaneously and no later than 21 days from the date the employer had notice or knowledge of the disability:

(1) Send the Notice of Temporary Compensation Payable, Form LIBC-501, to the employee or the employee's dependent.

(2) Pay compensation to the employee or to the employee's dependent.

(3) File the Notice of Temporary Compensation Payable, Form LIBC-501, with the Bureau.

(b) A Statement of Wages, Form LIBC-494A or Statement of Wages, Form LIBC-494C, shall be filed with every Notice of Temporary Compensation Payable, Form LIBC-501, except a Statement of Wages, Form LIBC-494A or Statement of Wages, Form LIBC-494C, may not be filed with a Notice of Temporary Compensation Payable, Form LIBC-501, filed under subsection (d).

(c) To modify a Notice of Temporary Compensation Payable, Form LIBC-501, an employer shall file an amended Notice of Temporary Compensation Payable, Form LIBC-501, with the Bureau during the 90-day temporary compensation payable period. The amended Notice of Temporary Compensation Payable, Form LIBC-501, shall be clearly identified as "Amended" and may have only the insurer's signature.

(1) A Statement of Wages, Form LIBC-494A, or Statement of Wages, Form LIBC-494C, shall be filed with every amended Notice of Temporary Compensation Payable, Form LIBC-501.

(2) This section does not apply upon conversion of the Notice of Temporary Compensation Payable, Form LIBC-501, to a Notice of Compensation Payable, Form LIBC-495.

(d) In medical only cases, when an employee's injury has not resulted in lost time from work, an employer may file a Notice of Temporary Compensation Payable, Form LIBC-501.

§ 121.8. Agreements for compensation for disability or permanent injury

(a) An Agreement for Compensation for Disability or Permanent Injury, Form LIBC-336, shall be completed before being signed by the employer and the employee. If the employer and the employee enter into an agreement, the employer shall do all of the following simultaneously and not later than 21 days from the date the employer had notice or knowledge of the disability:

(1) Send the fully-executed agreement to the employee.

(2) Pay compensation to the employee.

(3) File the agreement with the Bureau.

(b) A Statement of Wages, Form LIBC-494A, or Statement of Wages, Form LIBC-494C, shall be filed with every Agreement for Compensation for Disability or Permanent Injury, Form LIBC-336.

(c) If the employer has not obtained the wages necessary to properly calculate the employee's compensation payable, an Agreement for Compensation for Disability or Permanent Injury, Form LIBC-336, based upon the employee's estimated wages may be filed. The estimated Agreement for

Compensation for Disability or Permanent Injury, Form LIBC-336, shall be clearly identified as "Estimated."

(d) If the estimated wages or compensation is not correct, the employer shall amend the estimated Agreement for Compensation for Disability or Permanent Injury, Form LIBC-336, upon receipt of the employee's actual wages.

(1) Amendments resulting in an increase in the employee's wage or compensation shall be filed with the Bureau under § 121.12 (relating to Bureau review of agreements and notices of compensation payable), and shall be clearly identified as "Amended."

(2) The employer shall file a Supplemental Agreement for Compensation for Disability or Permanent Injury, Form LIBC-337, under § 121.17 (relating to change in compensation) when there are changes resulting in a decrease in the employee's wage or compensation.

§ 121.9. Agreements for compensation for death

(a) If a compensable injury results in death, an Agreement for Compensation for Death, Form LIBC-338, shall be executed between an employer and the deceased's dependents or personal representative and filed with the Bureau. An Agreement for Compensation for Death, Form LIBC-338, shall be completed before being signed by an employer and a deceased's dependents or personal representative.

(b) A Statement of Wages, Form LIBC-494A, or Statement of Wages, Form LIBC-494C, shall be filed with every Agreement for Compensation for Death, Form LIBC-338.

(c) If death results from the injury, compensation payments to the dependents for the death benefit shall begin from the date of the employee's death.

(d) If the employer has not obtained the wages necessary to properly calculate the employee's compensation payable, an Agreement for Compensation for Death, Form LIBC-338, based on the employee's estimated wages may be filed. The estimated Agreement for Compensation for Death, Form LIBC-338, shall be clearly identified as "Estimated."

(e) If the estimated wages or compensation is not correct, the employer shall amend the estimated Agreement for Compensation for Death, Form LIBC-338, upon receipt of the employee's actual wages.

(1) Amendments resulting in an increase in the employee's wage or dependent's compensation shall be filed with the Bureau under § 121.12 (relating to Bureau review of agreements and notices of compensation payable), and shall be clearly identified as "Amended."

(2) The employer shall file a Supplemental Agreement for Compensation for Disability or Permanent Injury, Form LIBC-337, under § 121.17 (relating to change in compensation) when there are changes resulting in a decrease in the employee's wage or compensation.

§ 121.10. [Reserved]

§ 121.11. Supplemental agreements for compensation for death

(a) A Supplemental Agreement for Compensation for Death, Form LIBC-339, may be used to change an Agreement for Compensation for Death, Form LIBC-338, or an award. A Supplemental

Agreement for Compensation for Death, Form LIBC-339, shall be completed before being signed by an employer and a deceased's dependents or personal representative.

(b) An Agreement for Compensation for Death, Form LIBC-338, shall be changed for any of the following reasons:

(1) Birth of a posthumous child.

(2) A change in dependent's status, including death.

(3) A surviving spouse dies, remarries or becomes capable of self-support and any dependent children remain eligible for benefits.

(c) The Bureau will presume that the surviving parent is guardian for purposes of receiving compensation under the act.

(d) The completed Supplemental Agreement for Compensation for Death, Form LIBC-339, shall be sent to all of the deceased's dependents or their personal representative and filed with the Bureau.

§ 121.12. Bureau review of agreements and notices of compensation payable

(a) Errors in computing wages shall be corrected by filing an amended version of the agreement or Notice of Compensation Payable, Form LIBC-495, with the Bureau if correction of errors would increase the employee's wage or compensation.

(1) The amended agreement or Notice of Compensation Payable, Form LIBC-495, shall be clearly identified as "Amended."

(2) A Statement of Wages, Form LIBC-494A, or Statement of Wages, Form LIBC-494C, shall be filed with every amended agreement or Notice of Compensation Payable, Form LIBC-495.

(b) The employer shall file a Supplemental Agreement for Compensation for Disability or Permanent Injury, Form LIBC-337, under § 121.17 (relating to change in compensation) when there are changes resulting in a decrease in the employee's wage or compensation.

§ 121.13. Denial of compensation

If compensation is controverted, a Notice of Workers' Compensation Denial, Form LIBC-496, shall be sent to the employee or dependent and filed with the Bureau, fully stating the grounds upon which the right to compensation is controverted, within 21 days after notice or knowledge to the employer of the employee's disability or death.

§ 121.14. Weekly wage for occupational disease cases

For cases involving occupational diseases under the act, the weekly wage will be determined in accordance with section 309 of the act (77 P. S. § 582), and a claimant's compensation rate shall be subject to the maximum compensation payable rate in effect at the date of last exposure.

§ 121.15. Compensation payable

(a) In computing the time when the disability becomes compensable, the day the injured employee is unable to continue at work by reason of the injury shall be counted as the first day of disability in the 7 day waiting period. If the injured employee is paid full wages for the day, shift or turn on

which the injury occurred, the following day shall be counted as the first day of disability. In determining the waiting period or time during which compensation is payable, each calendar day, including Sundays and holidays, shall be counted. In determining the period of disability, seven should be used as a divisor to determine the number, and any part, of the weeks.

(b) If death results from the injury, compensation payments to the dependents for death benefits shall begin from the date of the employee's death.

(c) If death results more than 7 days after the injury, compensation payments covering the disability period should be paid as set forth in this chapter, and compensation payments because of death due to the injury shall start from the date of death.

(d) Compensation due to the date of death shall be paid to the nearest of kin, or in the absence of same, to the estate.

§ 121.16. Updating claims status

(a) The following paragraphs apply to the Annual Claims Status Report, Form LIBC-774:

(1) The Bureau will provide the Annual Claims Status Report, Form LIBC-774, to an insurer each year before March 1.

(2) The insurer shall file a completed Annual Claims Status Report, Form LIBC-774, including any attachment required to support the data reported, to the Bureau each year before June 1.

(3) If an insurance carrier fails to file the completed report, the Bureau may recommend that the Insurance Commissioner revoke or suspend the insurance carrier's license under section 441(a) of the act (77 P. S. § 997(a)).

(4) If a self-insured employer fails to timely file the completed report, the Secretary of the Department may revoke or suspend the self-insured employer's privilege to carry its own risk under section 441(b) of the act.

(5) The Annual Claims Status Report must contain a list of all open claims which were initiated by the filing of a Bureau document other than a first report of injury, more than 3 calendar years before the calendar year in which the report is filed and on which no activity was reported to the Bureau during the calendar year immediately before the report year.

(6) Only open claims which were initiated with the Bureau during calendar year 2004 and thereafter may be listed in the Annual Claims Status Report.

(b) A Final Statement of Account of Compensation Paid, Form LIBC-392A, shall be filed with the Bureau immediately after the final payment of compensation.

§ 121.17. Change in Compensation

(a) If an injured employee has recovered from an injury, or a deceased employee's dependent or personal representative is no longer eligible to receive death benefits, an Agreement to Stop Weekly Workers' Compensation Payments (Final Receipt), Form LIBC-340, may be executed by the parties. The executed agreement shall be filed with the Bureau.

(b) Termination, suspension, modification or other change in compensation may be accomplished by filing with the Bureau a Supplemental Agreement for Compensation for Disability or Permanent

Injury, Form LIBC-337. A Supplemental Agreement for Compensation for Disability or Permanent Injury, Form LIBC-337, may be used to change an Agreement for Compensation for Disability or Permanent Injury, Form LIBC-336, a Supplemental Agreement for Compensation for Disability or Permanent Injury, Form LIBC-337, an Agreement for Compensation for Death, Form LIBC-338, a Notice of Compensation Payable, Form LIBC-495, or an award. A Supplemental Agreement for Compensation for Disability or Permanent Injury, Form LIBC-337, shall be completed before being signed by the employer and the employee. The completed Supplemental Agreement for Compensation for Disability or Permanent Injury, Form LIBC-337, shall be sent to the employee or his dependents and filed with the Bureau.

(c) A suspension or modification of compensation may be accomplished by the employer mailing a Notification of Suspension or Modification Pursuant to §§ 413 (c) and (d), Form LIBC-751, to the Bureau and the employee. The wage calculation on the Notification of Suspension or Modification Pursuant to §§ 413 (c) and (d), Form LIBC-751, shall be completed for a modification.

(d) If temporary payments made under § 121.7a (relating to notice of temporary compensation payable) are stopped, the employer shall file one of the following:

(1) A Notice Stopping Temporary Compensation, Form LIBC-502, and a Notice of Workers' Compensation Denial, Form LIBC-496, within 5 days of the last payment and within the 90-day temporary compensation payable period.

(2) A Notice of Compensation Payable, Form LIBC-495.

(3) An Agreement for Compensation for Disability or Permanent Injury, Form LIBC-336.

(e) The employer may not file a Notification of Suspension or Modification Pursuant to §§ 413(c) and (d), Form LIBC-751, to stop temporary payments made under § 121.7a.

(f) If termination, suspension or modification of compensation cannot be achieved through subsection (a), (b), (c) or (d), the employer may file a Petition To: Terminate (stop payment of workers' compensation), Terminate (based upon physician's affidavit, a special supersedeas hearing to be scheduled), Modify or Suspend Compensation Benefits, Form LIBC-378.

§ 121.18. Subrogation

(a) If an employee obtains a third-party recovery under section 319 of the act (77 P. S. § 671), a Third Party Settlement Agreement, Form LIBC-380, shall be executed by the parties.

(b) If credit is requested against future compensation payable, a Supplemental Agreement for Compensation for Disability or Permanent Injury, Form LIBC-337, may also be filed with the Bureau, including the amount and periodic method of pro rata reimbursement of attorney fees and expenses.

§ 121.19. [Reserved]

§ 121.20. Commutation of compensation under section 412 of the act (77 P. S. § 791)

Commutation under section 412 of the act (77 P. S. § 791) shall only be allowed for the final 52-week period or less. The commutation amount may not be paid in installments. A Commutation of Compensation, Form LIBC-498, shall be filed with the Bureau.

§ 121.21. Reimbursement for silicosis, anthraco-silicosis or coal workers' pneumoconiosis

(a) Claims for compensation for silicosis, anthracosilicosis or coal workers' pneumoconiosis as defined in section 108(q) of the act (77 P. S. § 27.1(q)), for disability or death, when the date of disability commences or death occurs between July 1, 1973, and June 30, 1976, inclusive, and when the liable employer is seeking to offset part of its liability under section 305.1 of the act (77 P. S. § 411.1), shall be instituted by filing a Claim Petition for Workers' Compensation, Form LIBC-362, with the Bureau.

(b) Unless stayed by a supersedeas on appeal, following the issuance of an award by the workers' compensation judge, the Board or the appellate court, compensation payments for silicosis, anthracosilicosis or coal workers' pneumoconiosis shall be made in full by the insurer. If the insurer seeks reimbursement from the Bureau under section 305.1 of the act, it shall submit the following to the Bureau:

(1) A notarized statement, signed by an officer of the company, containing an itemized list of payments made to all claimants for quarterly reimbursement. Each itemized entry must contain the claimant's name, address, Social Security number and the total amount paid to the claimant. Each itemized list shall be made for a full and exact calendar quarter: that is, January 1 through March 31; April 1 through June 30; July 1 through September 30; or October 1 through December 31. Each list must have two categories: recurring quarterly reimbursement and initial payment made to each claimant, which payment should include the current reimbursable quarter. Each list submitted must be in roster form and in numerical order according to the claimant's Social Security number, contain the claimant's name and Social Security number, cover the amount to be reimbursed and the total amount paid to the claimant, and be reported to the Bureau.

(2) Each bill containing the itemized entries shall be submitted to the Bureau no later than the 15th day of the month following the end of the calendar quarter for which reimbursement is sought. A bill received after that date will not be considered for payment until the end of the following quarter.

(c) For auditing purposes, an insurer shall keep records for 3 years from the date of each payment made under this section. The records shall be made available for inspection by the Bureau during normal business hours.

(d) If the Bureau believes that the insurer primarily liable for compensation under the act has failed to make a payment under the act and this section, the Bureau may pay compensation directly to the claimant, for the portion of the compensation which is payable by the Commonwealth under section 305.1 of the act until the insurer resumes payment of compensation. The Bureau is not required to initiate direct payments to a claimant when the insurer is making full payment of the compensation but is not seeking reimbursement under this section.

§ 121.22. Subsequent injury fund

(a) Compensation for a subsequent injury, as defined in section 306.1 of the act (77 P. S. § 516) shall be paid as follows:

(1) The employer is responsible for payments due for specific loss under section 306(c) of the act (77 P. S. § 513).

(2) Upon expiration of the specific loss period, the Bureau will be responsible for additional compensation due for the duration of total disability. The fund established under section 306.2

of the act (77 P. S. § 517), from which these payments are to be made, shall be maintained as follows:

(i) Self-insured employers shall pay assessments in amounts determined by the following:

Amount of Compensation Paid by a Self-Insured Employer During the Preceding Calendar Year	X	The Amount Expended From the Subsequent Injury Fund During the Preceding Calendar Year
Total Amount of Compensation Paid by All Insurers During the Preceding Calendar Year		

(ii) The amount expended from the Subsequent Injury Fund during the preceding calendar year, minus the total amount owed by all self-insured employers, as calculated under subparagraph (i), shall equal the aggregate amount to be collected by insurance carriers.

(b) Insurance carriers shall remit to the Bureau assessment amounts as follows:

Amount of Premium as Reported to the Insurance Department by Insurance Carrier for the Preceding Calendar Year	X	Aggregate Amount to be Collected by Insurance Carriers
Total Amount of Earned Premium Reported to the Insurance Department by All Insurance Carriers for the Preceding Calendar Year		

(c) If the amount of earned premium as reported to the Insurance Department, by an insurance carrier, for the preceding calendar year is less than zero, the Bureau will calculate the assessment amount as though an earned premium amount of zero were reported to the Insurance Department.

(d) Insured employers shall remit assessment amounts through their insurance carriers, according to procedures defined by the approved rating organization and approved by the Insurance Commissioner.

(e) Self-insured employers and runoff self-insurers shall pay assessments directly to the Bureau.

(f) The claimant shall file a Claim Petition for Additional Compensation from the Subsequent Injury Fund Pursuant to section 306.1 of the Workers' Compensation Act, Form LIBC-375, as provided in section 315 of the act (77 P. S. § 602) or the claim will be forever barred.

§ 121.23. Supersedeas fund

(a) Annual assessments under section 443 of the act (77 P. S. § 999) shall be in amounts determined by the following:

(1) Self-insured employers shall pay assessments in amounts determined by the following:

Amount of Compensation Paid by a Self-Insured Employer During the Preceding Calendar Year	X	The Amount of Supersedeas Payments Made or Accrued as Payable During the Preceding Calendar Year
Total Amount of Compensation Paid by All Insurers During the Preceding Calendar Year		

(2) The amount of supersedeas payments made or accrued as payable during the preceding year, minus the total amount owed by all self-insured employers, as calculated under paragraph (1), shall equal the aggregate amount to be collected by insurance carriers.

(3) Insurance carriers shall remit to the Bureau assessment amounts as follows:

Amount of Earned Premium as Reported to the Insurance Department, by Insurance Carrier for the Preceding Calendar Year	X	Aggregate Amount to be Collected by Insurance Carriers
Total Amount of Earned Premium Reported to the Insurance Department by all Insurance Carriers for the Preceding Calendar Year		

(b) If the amount of earned premium as reported to the Insurance Department, by an insurance carrier, for the preceding calendar year is less than zero, the Bureau will calculate the assessment amount as though an earned premium amount of zero were reported to the Insurance Department.

(c) Insured employers shall remit assessment amounts through their insurance carriers, according to procedures defined by the approved rating organization and approved by the Insurance Commissioner.

(d) Self-insured employers and runoff self-insurers shall pay assessments directly to the Bureau.

(e) Applications for reimbursement shall be filed directly with the Bureau on an Application for Supersedeas Fund Reimbursement, Form LIBC-662. Applications will be processed administratively to determine whether the parties can agree on the payment or amount of reimbursement. If the payment or amount of reimbursement cannot be agreed upon, the matter will be assigned to a workers' compensation judge for a formal hearing and adjudication.

§ 121.24. [Reserved]

§ 121.25. Issuance of compensation payments

Compensation payments shall be issued according to the following:

(1) Unless the claimant and the employer have executed an Authorization for Alternative Delivery of Compensation Payments, Form LIBC-10, or unless payment is otherwise ordered by a workers' compensation judge, the Board or any court, a claimant's payment for workers' compensation or occupational disease compensation shall be mailed by first-class mail to the claimant's last known address, and may not be made payable to, or delivered to, an attorney unless the attorney is the

administrator or executor of the claimant's estate, a court-appointed trustee, a court-appointed guardian or acting in some other fiduciary capacity.

(2) Notice of the first payment to a claimant shall be sent to counsel of record by the insurer or self-insured employer.

(3) If a workers' compensation judge or the Board approves attorneys' fees and costs, a payment for fees and costs, separate from a compensation payment, shall be made payable, and issued, to the claimant's attorney.

(4) An employer may not require a claimant to appear at a specific place to receive compensation payments.

§ 121.26. [Reserved]

§ 121.27. Orders to show cause

(a) The Department may serve an order to show cause on a respondent for an alleged violation of the act or regulations contained in this part. The order to show cause will contain the particulars of the alleged violation and the procedures for filing an answer under subsection (b).

(b) A written answer to the order to show cause may be filed no later than 20 days after the date that the order to show cause is served on the respondent. The answer must admit or deny the allegations in the order to show cause and state respondent's defense. General denials that are unsupported by specific facts will not comply with this section and may be deemed a basis for entry of a final order because the respondent has raised no issues requiring further proceedings. The facts in the order to show cause may be deemed admitted if a respondent fails to file a timely answer under this subsection.

(c) The Director of Adjudication will assign the order to show cause to a presiding officer who will schedule a hearing. The presiding officer will provide notice to the parties of the hearing date, time and place.

(d) The hearing will be conducted under this section and 1 Pa. Code Part II (relating to General Rules of Administrative Practice and Procedure) to the extent not specifically superseded in subsection (h). The presiding officer will not be bound by strict rules of evidence.

(e) Hearings will be stenographically recorded and the transcript of the proceedings will be part of the record.

(f) If the respondent fails to appear in person or by counsel at the scheduled hearing without adequate excuse, the presiding officer will decide the matter on the basis of the order to show cause and evidence presented.

(g) The Department has the burden to demonstrate, upon a preponderance of the evidence, that the respondent failed to comply with the act or regulations in this part.

(h) This section supersedes 1 Pa. Code §§ 35.14, 35.37, 35.131, 35.201 and 35.221.

§ 121.27a. Bureau intervention and penalties

(a) If the workers' compensation judge determines that penalties resulting from an alleged violation of the act or regulations in this part may be imposed on a party under section 435 of the act (77 P. S. §

991), the workers' compensation judge may notify the Bureau in writing within 20 days of the notice of the alleged violation.

(b) The workers' compensation judge will include a description of the nature of the alleged violation in the notice and will provide the Bureau with an opportunity to participate in the proceeding as an intervening party. The workers' compensation judge simultaneously will provide a copy of the notification to all parties.

(c) Within 20 days after receipt of the notice, the Bureau will notify the workers' compensation judge and the parties of its decision to participate in the proceeding or to allow the proceeding to continue without intervention. If the Bureau fails to respond to the notification within 20 days, the Bureau will not have intervened. By not intervening before the workers' compensation judge, the Bureau has not waived its right to intervene in a different forum or following additional notice from the workers' compensation judge in the same proceeding.

(d) Nothing in this section may be construed to require the Bureau to intervene in any matter or to restrain a workers' compensation judge from notifying the Bureau of a further alleged violation of the act or regulations in a case.

(e) This section supplements §§ 131.121 and 131.122 (relating to penalty proceedings initiated by a party; and other penalty proceedings).

§ 121.28. [Reserved]

§ 121.29. [Reserved]

§ 121.30. Section 306(h) payments (77 P. S. § 583)

(a) Under section 306(h) of the act (77 P. S. § 583), insurers shall submit a listing of all pre-August 31, 1993, cases on which compensation is still payable under sections 306(a), 306(23) or 307 of the act (77 P. S. §§ 511, 513(23), 561, 562 and 542), in an amount less than $100 per week on January 1, 2007. This listing must contain the following particulars:

(1) Bureau code.

(2) Name of claimant.

(3) Social Security number.

(4) Claimant's date of birth.

(5) Date of injury.

(6) Name of employer.

(7) Insurer claim number.

(8) Current weekly compensation rate.

(b) If the insurer seeks reimbursement from the Bureau under section 306(h) of the act, it shall submit the following to the Bureau on a quarterly basis: a notarized statement, signed by an officer of the company, containing an itemized list of payments made to all claimants, submitted no later than the 10th day of the month following the quarter for which advance reimbursement payments have been

made. Each itemized entry must contain the following information: the claimant's name, Social Security number and the total amount paid each claimant per quarter.

(c) Changes in a payment schedule to an individual shall be reported to the Bureau within 10 days of the change. The Bureau will take credit in the following reimbursable quarter for an overpayment caused by change in a payment schedule.

(d) For auditing purposes, every insurer shall keep records for 3 years from the date of each payment made under this section. The records will be made available for inspection by the Bureau during normal business hours.

(e) If the Bureau believes that the insurer primarily liable for compensation under the act has failed to make a payment under the act and this section, the Bureau may pay compensation directly to the claimant, for the portion of the compensation which is payable by the Commonwealth under section 306(h) of the act until the insurer resumes payment of compensation. The Bureau is not required to initiate direct payments to a claimant when the insurer is making full payment of the compensation but is not seeking reimbursement under this section.

§ 121.31. Workers' Compensation Administration Fund

(a) Annual assessments on self-insured employers, under section 446(b) of the act (77 P. S. § 1000.2(b)), shall be in amounts determined by the following:

Amount of Compensation Paid by a Self-Insured Employer During the Preceding Calendar Year / Total Amount of Compensation Paid by All Insurers During the Preceding Calendar Year	X	The Approved Budget of the Workmen's Compensation Administration Fund for the Current Fiscal Year

(b) The approved budget of the Workmen's Compensation Administration Fund for the current fiscal year, minus the total amount owed by all self-insured employers, as calculated under subsection (a), shall equal the aggregate amount to be collected by insurance carriers.

(c) Insurance carriers shall remit to the Bureau assessment amounts as follows:

Amount of Earned Premium as Reported to the Insurance Department by an Insurance Carrier for the Preceding Calendar Year / Total Amount of Earned Premium Reported to the Insurance Department by All Insurance Carriers for the Preceding Calendar Year	X	Aggregate Amount to be Collected by Insurance Carriers

(d) If the amount of earned premium as reported to the Insurance Department, by an insurance carrier, for the preceding calendar year is less than zero, the Bureau will calculate the assessment amount as though an earned premium amount of zero were reported to the Insurance Department.

(e) Insured employers shall remit assessment amounts through their insurance carriers, according to procedures defined by the approved rating organization and approved by the Insurance Commissioner.

(f) Self-insured employers and runoff self-insurers shall pay assessments directly to the Bureau.

§ 121.32. Office of Small Business Advocate

(a) The Bureau may collect annual assessments imposed on insurance carriers, but not on self-insured employers or runoff self-insurers, for the purpose of funding the Office of Small Business Advocate in accordance with section 1303 of the act (77 P. S. § 1041.3). Insurance carriers shall be directly liable to the Bureau for prompt payment of assessments for the Office of Small Business Advocate, as provided in the act and this chapter.

(b) Annual assessments under section 1303 of the act shall be in amounts as determined by the following formula:

Amount of Compensation Paid by an Insurance Carrier, but not a Self-Insured Employer or Runoff Self-Insurer, During the Preceding Calendar Year	X	The Approved Budget of the Office of Small Business Advocate for the Current Fiscal Year
Total Amount of Compensation Paid by All Insurance Carriers, but not Self-Insured Employers or Runoff Self-Insurers, During the Preceding Calendar Year		

§ 121.33. Collection of special funds assessments

(a) The Bureau will collect assessments for the special funds by calculating the total amount of the following:

(1) What each self-insured employer is liable for paying to the Bureau.

(2) What each insurance carrier is responsible for collecting from insured employers and remitting to the Bureau.

(b) Assessments for the special funds will be imposed, collected and remitted as follows:

(1) The Bureau will transmit to each insurance carrier and self-insured employer a notice of assessment amount to be collected, which will specify the amount calculated under subsection (a) and the date on which the amount is due.

(2) Each self-insured employer shall timely remit to the Bureau the amount calculated under subsection (a)(1).

(3) Each insurance carrier shall collect payment for assessments from insured employers according to the procedures defined by the approved rating organization and approved by the Insurance Commissioner and timely remit payment to the Bureau.

(4) The failure of an insurance carrier to receive payment from an insured employer does not limit an insurance carrier's responsibility to collect and timely remit to the Bureau the total amount calculated under subsection (a)(2).

§ 121.34. Objections to assessments

(a) A party receiving a notice of assessment amount to be collected from the Bureau may, within 15 days of receipt, object to the assessment reflected in the notice on the basis that it is excessive, erroneous, unlawful or invalid. Insured employers retain all rights provided under section 717 of the act (77 P. S. § 1035.17).

(b) Objections must be set forth in numbered paragraphs, specifically state the facts necessary to determine the validity of the challenged assessment or assessment amount and be accompanied by a supporting memorandum documenting the legal grounds for the objections.

(c) An objection to assessment or assessment amount shall be accompanied by a proof of service as specified in 1 Pa. Code § 33.35 (relating to proof of service) and a notice of appearance as specified in 1 Pa. Code § 31.24 (relating to notice of appearance), and be served on all interested parties as specified in 1 Pa. Code § 33.32 (relating to service by a participant).

(d) An objection not conforming to this section or the act will be rejected by the Bureau. The Bureau will notify the objecting party of the specific reasons for the rejection. The objecting party shall have 30 days to cure any deficiency.

(e) Upon receipt of an objection which conforms to this section and the act, the Department will hold a hearing in accordance with 1 Pa. Code Part II (relating to General Rules of Administrative Practice and Procedure). After the hearing, the Department will record its findings on any objections and will transmit to the objector, by registered or certified mail, notice of the amount, if any, charged against it in accordance with the findings. The amount shall be paid by the objector within 10 days after receipt of the findings. After payment has been made, the objector may initiate an action in the appropriate court to recover the payment of the assessment or any portion thereof. An insurer may not maintain an action to recover payment unless it has previously objected under subsection (a).

§ 121.35. Annual reports of compensation paid

Every annual report of compensation paid made by an insurer under sections 445 and 446(e) of the act (77 P. S. §§ 1000.1 and 1000.2(e)) must include amounts paid by an insurer for which policyholders have agreed to reimburse the insurer under deductible policies issued under section 448 of the act (77 P. S. § 1000.4).

TITLE 34. LABOR AND INDUSTRY

PART VIII. BUREAU OF WORKERS' COMPENSATION

CHAPTER 123. GENERAL PROVISIONS PART II

SUBCHAPTER A. OFFSET OF UNEMPLOYMENT COMPENSATION, SOCIAL SECURITY (OLD AGE), SEVERANCE AND PENSION BENEFITS

§ 123.1. Purpose

This subchapter interprets the provisions of the act which authorize the offset of workers' compensation benefits by amounts received in unemployment compensation, Social Security (old age), severance and pension benefits, subsequent to the work-related injury. Offsets shall be dollar-for-dollar and calculated as set forth in §§ 123.4 — 123.11. Offsets in excess of the weekly workers' compensation rate shall accumulate as a credit toward the future payment of workers' compensation benefits.

§ 123.2. Definitions

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

ADR — Alternative Dispute Resolution.

Act — The Workers' Compensation Act (77 P. S. §§ 1 — 2626).

Actuarial equivalent — The value of lump-sum pension payout in terms of a monthly benefit if the funds had been used to purchase an annuity (either qualified joint and survivor or life annuity) available on the market, considering interest and mortality, at the time of the employe's receipt of the lump-sum benefit.

CBA — Collective Bargaining Agreements.

Defined-benefit plan — A pension plan in which the benefit level is established at the commencement of the plan and actuarial calculations determine the varying contributions necessary to fund the benefit at an employe's retirement.

Defined-contribution plan — A pension plan which provides for an individual account for each participant and for benefits based solely upon the amount of accumulated contributions and earnings in the participant's account. At the time of retirement the accumulated contributions and earnings determine the amount of the participant's benefit either in the form of a lump-sum distribution or annuity.

IRA — An individual retirement account as that term is utilized in 26 U.S.C.A. §§ 219 and 408(a).

IRE — Impairment Rating Evaluation.

Multi-employer pension plan — A plan to which more than one employer is required to contribute and is maintained under one or more collective bargaining agreements between one or more employe organizations and more than one employer.

Net — The amount of unemployment compensation, Social Security (old age), severance or pension benefits received by the employe after required deductions for local, State and Federal taxes and amounts deducted under the Federal Insurance Contributions Act (FICA) (26 U.S.C.A. §§ 3101—3126).

Pension — A plan or fund established or maintained by an employer, an employe organization, or both, which provides retirement income, in the form of retirement or disability benefits to employes or which results in deferral of income by employes extending to termination of employment and beyond.

Severance benefit — A benefit which is taxable to the employe and paid as a result of the employe's separation from employment by the employer liable for the payment of workers' compensation, including benefits in the form of tangible property. The term does not include payments received by the employee based on unused vacation or sick leave or otherwise earned income.

Social Security (old age) benefits — Benefits received by an employee under the Social Security Act (42 U.S.C.A. §§ 301 — 1397(e)) relating to Social Security retirement income.

§ 123.3. Employe report of benefits subject to offset

(a) Employes shall report to the insurer amounts received in unemployment compensation, Social Security (old age), severance and pension benefits on form LIBC-756, "Employee's Report of Benefits." This includes amounts withdrawn or otherwise utilized from pension benefits which are rolled over into an IRA or other similarly restricted account while at the same time the employe is receiving workers' compensation benefits.

(b) Form LIBC-756 shall be completed and forwarded to the insurer within 30 days of the employe's receipt of any of the benefits specified in subsection (a) or within 30 days of any change in the receipt of the benefits specified in subsection (a), but at least every 6 months.

§ 123.4. Application of the offset generally

(a) After receipt of Form LIBC-756, the insurer may offset workers' compensation benefits by amounts received by the employe from any of the sources in § 123.3 (relating to employe report of benefits subject to offset). The offset of workers' compensation benefits only applies with respect to amounts of unemployment compensation, Social Security (old age), severance and pension benefits received subsequent to the work-related injury.

(1) The offset applies only to wage-loss benefits (as opposed to medical benefits, specific loss or survivor benefits).

(2) The offset for amounts received in Social Security (old age), severance and pension benefits only applies to individuals with claims for injuries suffered on or after June 24, 1996.

(3) The offset for amounts received in unemployment compensation benefits applies to all claims regardless of the date of injury.

(b) At least 20 days prior to taking the offset, the insurer shall notify the employe, on Form LIBC-761, "Notice of Workers' Compensation Benefit Offset," that the workers' compensation benefits will be offset. The notice shall indicate:

(1) The amount of the offset.

(2) The type of offset (that is — unemployment compensation, Social Security (old age), severance or pension).

(3) How the offset was calculated, with supporting documentation, which may include information provided by the employe.

(4) When the offset commences.

(5) The amount of any recoupment, if applicable.

(c) Whenever the insurer's entitlement to the offset changes, the insurer shall notify the employe of the change at least 20 days prior to the adjustment on Form LIBC-761.

(d) The insurer shall provide a copy of Form LIBC-761, to the employe, the employe's counsel, if known, and the Department. The form shall be provided to the employe consistent with section 406 of the act (77 P. S. § 717).

(e) The employe may challenge the offset by filing a petition to review offset with the Department.

(f) When Federal, State or local taxes are paid with respect to amounts an employe receives in unemployment compensation, Social Security (old age), severance or pension benefits, the insurer shall repay the employe for amounts previously offset, and paid in taxes, from workers' compensation benefits, when the offset was calculated on the pretax amount of the benefit received. To request repayment for amounts previously offset and paid in taxes, the employe shall notify the insurer in writing of the amounts paid in taxes previously included in the offset.

§ 123.5. Offset for benefits already received

(a) If the insurer receives information that the employe has received benefits from one or more of the sources in § 123.3 (relating to employe report of benefits subject to offset) subsequent to the date of injury, the insurer may be entitled to an offset to the workers' compensation benefit.

(b) The net amount received by the employe shall be calculated consistent with §§ 123.6 — 123.11. The amount received by the employe shall be divided by the weekly workers' compensation rate. The result shall be the number of weeks, and fraction thereof, the insurer is entitled to offset against future payments of workers' compensation benefits.

(c) The insurer shall notify the employe, the employe's counsel, if known, and the Department of the offset as specified in § 123.4(b) (relating to application of the offset generally).

(d) The employe may challenge the offset by filing a petition to review offset with the Department.

§ 123.6. Application of offset for Unemployment Compensation (UC) benefits

(a) Workers' compensation benefits otherwise payable shall be offset by the net amount an employe receives in UC benefits subsequent to the work-related injury. This offset applies only to UC benefits which an employe receives and which are attributable to the same time period in which an employe also receives workers' compensation benefits.

(b) The offset may not apply to benefits for which an employe may be eligible, but is not receiving.

(c) The offset to workers' compensation benefits for amounts received in UC benefits is triggered when an employe becomes eligible for and begins receiving the UC benefits:

(1) When an employe receives UC benefits which the employe is later required to repay based upon a determination of ineligibility, the insurer may not offset the workers' compensation benefits.

(2) When an employe's workers' compensation benefits have been offset by the amount received in UC benefits, and the employe is required to repay UC benefits based upon a determination of ineligibility, the insurer shall repay the employe for the amounts previously offset from the workers' compensation benefits. The employe may request that the insurer remit repayment directly to the Bureau of Unemployment Compensation Benefits and Allowances (BUCBA).

(d) When an employe receives a lump-award from BUCBA, the insurer may offset the amount received by the employe against future payments of workers' compensation benefits. The amount received by the employe shall be divided by the weekly workers' compensation rate. The result shall be the number of weeks, and fraction thereof, the insurer is entitled to offset against future payments of workers' compensation benefits.

§ 123.7. Application of offset for Social Security (old age) benefits

(a) Workers' compensation benefits otherwise payable shall be offset by 50% of the net amount received in Social Security (old age) benefits. The offset shall only apply to amounts which an employe receives subsequent to the work-related injury. The offset may not apply to Social Security (old age) benefits which commenced prior to the work-related injury and which the employe continues to receive subsequent to the work-related injury.

(b) The offset may not apply to benefits to which an employe may be entitled, but is not receiving.

(c) The offset shall be applied on a weekly basis. To calculate the weekly offset, 50% of the net monthly Social Security (old age) benefit received by the employe shall be divided by 4.34.

§ 123.8. Offset for pension benefits generally

(a) Workers' compensation benefits otherwise payable shall be offset by the net amount an employe receives in pension benefits to the extent funded by the employer directly liable for the payment of workers' compensation.

(b) The pension offset shall apply to amounts received from defined-benefit and defined-contribution plans.

(c) The offset may not apply to pension benefits to which an employe may be entitled, but is not receiving.

(d) In calculating the offset amount for pension benefits, investment income attributable to the employer's contribution to the pension plan shall be included on a prorata basis.

§ 123.9. Application of offset for pension benefits

(a) Offsets of amounts received from pension benefits shall be achieved on a weekly basis. If the employe receives the pension benefit on a monthly basis, the net amount contributed by the employer and received by the employe shall be divided by 4.34. The result is the amount of the weekly offset to the workers' compensation benefit.

(b) When an employe receives a pension benefit in the form of a lump-sum payment, the actuarial equivalent of the lump-sum with respect to the annuity options (qualified joint and survivor annuity or life annuity) available at the time of the employe's receipt shall be used as the basis for calculating the offset to the workers' compensation benefit. The monthly annuity equivalent shall be divided by 4.34. The result shall be the offset to the workers' compensation benefit on a weekly basis.

(c) Pension benefits which are rolled over into an IRA or other similarly restricted account may not offset workers' compensation benefits, so long as the employe does not withdraw or otherwise utilize the pension benefits from the restricted account while simultaneously receiving workers' compensation benefits from the liable employer.

(d) If the employe, while receiving workers' compensation benefits from the liable employer, withdraws or otherwise utilizes pension benefits from the IRA or other similarly restricted account, when the IRA or account is funded in whole or in part by the liable employer's contributions, the insurer is entitled to an offset to workers' compensation benefits.

(1) If the employe begins receiving a monthly payment from the IRA or other similarly restricted account, the insurer shall receive an offset to the workers' compensation benefit equal to the offset the insurer would be entitled to if the employe were receiving a monthly pension benefit under subsection (a).

(2) If the employe withdraws or otherwise utilizes an amount from the IRA or other similarly restricted account which is greater than the actuarial equivalent of the lump sum with respect to the annuity options (qualified joint and survivor annuity or life annuity) available at the time of the employe's receipt, the insurer shall be entitled to an offset against future payments of workers' compensation benefits in an amount equal to the amount of the pension benefit withdrawn or otherwise utilized by the employe. The amount of the pension benefit withdrawn or otherwise utilized by the employe shall be divided by the weekly workers' compensation rate. The result shall be the number of weeks, and fraction thereof, the insurer may offset against future payments of workers' compensation benefits.

(e) The employe shall report the subsequent receipt of pension benefits from the IRA or other similarly restricted account to the insurer on Forms LIBC-756 and LIBC-750, "Employee Report of Wages (Other Than Workers' Compensation Benefits Received)."

§ 123.10. Multi-employer pension fund offsets

(a) When the pension benefit is payable from a multi-employer pension plan, only that amount which is contributed by the employer directly liable for the payment of workers' compensation shall be used in calculating the offset to workers' compensation benefits.

(b) To calculate the appropriate offset amount, the portion of the annuity purchased by the liable employer's contributions shall be as determined by the pension fund's actuary. The ratio of the portion of the annuity purchased by the liable employer's contributions to the total annuity shall be multiplied by the net benefit received by the employe from the pension fund on a weekly basis. The result is the amount of the offset to be applied to the workers' compensation benefit on a weekly basis.

(c) If the employe receives the multi-employer pension benefit on a monthly basis, the net amount received by the employe shall be multiplied by the ratio of the liable employer's contribution to the pension plan on behalf of the employe and that product shall be divided by 4.34. The result is the amount of the offset to be applied to the workers' compensation benefit on a weekly basis.

(d) If the employe receives the multi-employer pension benefit in a lump sum, the actuarial equivalent of the lump sum with respect to the annuity options (qualified joint and survivor annuity or life annuity) available at the time of the employe's receipt of the benefit shall be used as the basis for calculating the offset to the workers' compensation benefit. The ratio of the employer's contribution to the pension plan shall be multiplied by the monthly annuity value of the pension benefit. The

result shall be divided by 4.34 to achieve the offset to the workers' compensation benefit on a weekly basis.

§ 123.11. Application of offset for severance benefits

(a) Workers' compensation benefits otherwise payable shall be offset by amounts an employe receives in severance benefits subsequent to the work-related injury. The offset may not apply to severance benefits to which an employe may be entitled, but is not receiving.

(b) The net amount of any severance benefits shall offset workers' compensation benefits on a weekly basis except as provided in subsections (c) and (d).

(c) When the employe receives severance benefits in a lump-sum payment, the net amount received by the employe shall be divided by the weekly workers' compensation rate. The result is the number of weeks, and fraction thereof, the insurer may offset against future payments of workers' compensation benefits.

(d) When an employe receives a severance benefit in the form of tangible property, the market value of the property, as determined for Federal tax purposes, shall be divided by the weekly workers' compensation rate. The result is the number of weeks, and fraction thereof, the insurer may offset against future payments of workers' compensation benefits.

SUBCHAPTER B. IMPAIRMENT RATINGS

§ 123.101. Purpose

This subchapter interprets section 306(a.2) of the act (77 P. S. § 511.2) which provides for a determination of whole body impairment due to the compensable injury after the receipt of 104 weeks of total disability compensation, unless otherwise agreed to by the parties.

§ 123.102. IRE requests

(a) During the 60-day period subsequent to the expiration of the employe's receipt of 104 weeks of total disability benefits, the insurer may request the employe's attendance at an IRE. If the evaluation is scheduled to occur during this 60-day time period, the adjustment of the benefit status shall relate back to the expiration of the employe's receipt of 104 weeks of total disability benefits. In all other cases, the adjustment of the disability status shall be effective as of the date of the evaluation or as determined by the evaluating physician.

(b) Absent agreement between the insurer and the employe, an IRE may not be performed prior to the expiration of the employe's receipt of 104 weeks of total disability benefits.

(c) When an insurer requests the employe's attendance at an IRE during the 60-day period subsequent to the expiration of the employe's receipt of 104 weeks of total disability benefits and the employe fails, for any reason, to attend the IRE, when the failure results in the performance of the IRE more than 60 days beyond the expiration of the 104-week period, the adjustment of disability status shall relate back to the expiration of the employe's receipt of 104 weeks of total disability benefits.

(d) The employe's receipt of 104 weeks of total disability benefits shall be calculated on a cumulative basis.

(e) The insurer shall request the employe's attendance at the IRE in writing on Form LIBC-765, "Impairment Rating Evaluation Appointment," and specify therein the date, time and location of the

evaluation and the name of the physician performing the evaluation, as agreed by the parties or designated by the Department. The request shall be made to the employe and employe's counsel, if known.

(f) Consistent with section 306(a.2)(6) of the act (77. P. S. § 511.2), the insurer's failure to request the evaluation during the 60-day period subsequent to the expiration of the employee's receipt of 104 weeks of total disability benefits may not result in a waiver of the insurer's right to compel the employe's attendance at an IRE.

(g) The insurer maintains the right to request and receive an IRE twice in a 12-month period. The request and performance of IREs may not preclude the insurer from compelling the employe's attendance at independent medical examinations or other expert interviews under section 314 of the act (77 P. S. § 651).

(h) The employe's failure to attend the IRE under this section may result in a suspension of the employe's right to benefits consistent with section 314(a) of the act.

§ 123.103. Physicians

(a) Physicians performing IREs shall:

(1) Be licensed in this Commonwealth and certified by an American Board of Medical Specialties-approved board or its osteopathic equivalent.

(2) Be active in clinical practice at least 20 hours per week.

(b) For purposes of this subchapter, the phrase "active in clinical practice" means the act of providing preventive care and the evaluation, treatment and management of medical conditions of patients on an ongoing basis.

(c) Physicians chosen by employes to perform IREs, for purposes of appealing a previous adjustment of benefit status, shall possess the qualifications in subsection (a) and shall be active in clinical practice as specified in subsection (b).

(d) In addition to the requirements of subsections (a) and (b), physicians designated by the Department to perform IREs shall meet training and certification requirements which may include, but are not limited to, one or more of the following:

(1) Required attendance at a Departmentally approved training course on the performance of evaluations under the AMA "Guides to the Evaluation of Permanent Impairment."

(2) Certification upon passage of a Departmentally approved examination on the AMA "Guides to the Evaluation of Permanent Impairment."

(3) Other requirements as approved by the Department.

§ 123.104. Initial IRE; designation of physician by Department

(a) The insurer is responsible for scheduling the initial IRE. Only the insurer may request that the Department designate an IRE physician.

(b) The Department's duty to designate an IRE physician pertains only to the initial IRE. A list of Departmentally approved IRE physicians will be available upon request.

(c) The request to designate a physician shall be made on Form LIBC-766, "Request for Designation of a Physician to Perform an Impairment Rating Evaluation."

(d) Within 20 days of receipt of the designation request, the Department will designate a physician to perform the IRE.

(e) The Department will provide the name and address of the physician designated to perform the IRE to the employee, the insurer and the attorneys for the parties, if known.

§ 123.105. Impairment rating determination

(a) When properly requested under § 123.102 (relating to IRE requests), an IRE shall be conducted in all cases and an impairment rating determination must result under the most recent edition of the AMA "Guides to the Evaluation of Permanent Impairment."

(b) To ascertain an accurate percentage of the employee's whole body impairment, when the evaluating physician determines that the compensable injury incorporates more than one pathology, the evaluating physician may refer the employee to one or more physicians specializing in the specific pathologies which constitute the compensable injury. Any physician chosen by the evaluating physician to assist in ascertaining the percentage of whole body impairment shall possess the qualifications as specified in § 123.103(a) and (b) (relating to physicians). The referring physician remains responsible for determining the whole body impairment rating of the employee.

(c) The physician performing the IRE shall complete Form LIBC-767, "Impairment Rating Determination Face Sheet" (Face Sheet), which sets forth the impairment rating of the compensable injury. The physician shall attach to the Face Sheet the "Report of Medical Evaluation" as specified in the AMA "Guides to the Evaluation of Permanent Impairment." The Face Sheet and report shall be provided to the employee, employee's counsel, if known, insurer and the Department within 30 days from the date of the impairment evaluation.

(d) If the evaluation results in an impairment rating of less than 50%, the employee shall receive benefits partial in character. To adjust the status of the employee's benefits from total to partial, the insurer shall provide notice to the employee, the employee's counsel, if known, and the Department, on Form LIBC-764, "Notice of Change in Workers' Compensation Disability Status," of the following:

(1) The evaluation has resulted in an impairment rating of less than 50%.

(2) Sixty days from the date of the notice the employee's benefit status shall be adjusted from total to partial.

(3) The adjustment of benefit status does not change the amount of the weekly workers' compensation benefit.

(4) An employee may only receive partial disability benefits for a maximum of 500 weeks.

(5) The employee may appeal the adjustment of benefit status to a workers' compensation judge by filing a Petition for Review with the Department.

(e) If the evaluation results in an impairment rating that is equal to or greater than 50%, the employee shall be presumed to be totally disabled and shall continue to receive total disability compensation. The presumption of total disability may be rebutted at any time by a demonstration of earning power in accordance with section 306(b)(2) of the act (77 P. S. § 512(b)(2)) or by a subsequent IRE which results in an impairment rating of less than 50%.

(f) At any time during the receipt of 500 weeks of partial disability compensation, the employee may appeal the adjustment of benefit status to a workers' compensation judge by filing a Petition for Review.

SUBCHAPTER C. QUALIFICATIONS FOR VOCATIONAL EXPERTS APPROVED BY THE DEPARTMENT

§ 123.201. Purpose

This subchapter implements and interprets provisions of the act which permit the Department to establish qualifications for vocational experts who will conduct earning power assessment interviews under sections 306(b) and 449 of the act (77 P. S. §§ 512 and 1000.5). This subchapter also implements the act's requirements for compliance with the Code of Professional Ethics for Rehabilitation Counselors pertaining to the conduct of expert witnesses and disclosure of financial interest.

§ 123.201a. [Reserved]

§ 123.201b. Definitions

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

Financial interest — An interest equated with money or its equivalent, and includes any of the following:

(i) A present or former ownership interest in or with the entity or individual conducting the earning power assessment interview.

(ii) A present or former employment relationship with the entity or individual conducting the earning power assessment interview.

(iii) A contractual or referral arrangement that would require or allow the insurer to provide compensation or other consideration based upon the vocational expert's opinion or the outcome of the vocational expert's earning power assessment interview.

Insurer — An insurer is any of the following:

(i) A workers' compensation insurance carrier.

(ii) The State Workers' Insurance Fund of the Department.

(iii) An employer authorized by the Department to self-insure its workers' compensation liability under section 305 of the act (77 P. S. § 501).

(iv) 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).

§ 123.202. Qualifications for current vocational experts under Act 57 of 1996

(a) This section applies to individuals who, before June 23, 2007, conducted earning power assessment interviews under section 306(b) of the act (77 P. S. § 512). These individuals continue to meet the minimum qualifications established under section 306(b) if they possess one of the following:

(1) Both of the following:

(i) Certification by one of the following Nationally recognized professional organizations:

(A) The American Board of Vocational Experts.

(B) The Commission on Rehabilitation Counselor Certification.

(C) The Commission on Disability Management Specialists Certification.

(D) The National Board of Certified Counselors.

(E) Other Nationally recognized professional organizations published by the Department in the *Pennsylvania Bulletin.*

(ii) One year experience in analyzing labor market information and conditions, industrial and occupational trends, with primary duties providing actual vocational rehabilitation services, which include the following:

(A) Job seeking skills.

(B) Job development.

(C) Job analysis.

(D) Career exploration.

(E) Placement of individuals with disabilities.

(F) Vocational testing and assessment.

(2) Certification by a Nationally recognized professional organization specified in paragraph (1)(i) under the direct supervision of an individual possessing the criteria in paragraph (1).

(3) Possession of a Bachelor's degree or a valid license issued by the Department of State's Bureau of Professional and Occupational Affairs, as long as the individual is under the direct supervision of an individual possessing the criteria in paragraph (1).

(4) At least 5 years experience primarily in the workers' compensation field prior to August 23, 1996, as a vocational evaluator, with experience in analyzing labor market information and conditions, industrial and occupational trends, with primary duties providing actual vocational rehabilitation services, which include, but are not limited to, the following:

(i) Job seeking skills.

(ii) Job development.

(iii) Job analysis.

(iv) Career exploration.

(v) Placement of individuals with disabilities.

(b) Individuals meeting the minimum qualifications under subsection (a) are approved to conduct earning power assessment interviews under section 449 of the act (77 P. S. § 1000.5).

§ 123.202a. Qualifications for vocational experts under Act 53 of 2003

(a) This section applies to individuals who, before June 23, 2007, have not conducted earning power assessment interviews under section 306(b) of the act (77 P. S. § 512). These individuals meet the minimum qualifications established under section 306(b) if they possess both:

(1) Certification by one of the following Nationally recognized professional organizations:

(i) The American Board of Vocational Experts.

(ii) The Commission on Rehabilitation Counselor Certification.

(iii) The Commission on Disability Management Specialists Certification.

(iv) Other Nationally recognized professional organizations, published by the Department in the Pennsylvania Bulletin.

(2) A bachelor's or postgraduate degree in rehabilitation counseling or a related counseling field.

(b) Individuals meeting the minimum qualifications under subsection (a) are approved to conduct earning power assessment interviews under section 449 of the act (77 P. S. § 1000.5).

§ 123.203. Role of workers' compensation judges

(a) A workers' compensation judge will resolve disputes regarding whether a vocational expert meets the minimum qualifications established in §§ 123.202 and 123.202a (relating to qualifications for current vocational experts under Act 57 of 1996; and qualifications for vocational experts under Act 53 of 2003).

(b) Except as set forth in subsection (c), this subchapter does not limit a workers' compensation judge's authority to determine a vocational expert's qualifications under §§ 123.202 and 123.202a or a vocational expert's bias or objectivity.

(c) A workers' compensation judge may not consider the results of an earning power assessment interview if the workers' compensation judge finds that the vocational expert has not complied with § 123.204 (relating to conduct of vocational experts) or that the insurer has not complied with § 123.205 (relating to financial interest disclosure).

§ 123.204. Conduct of vocational experts

(a) Before conducting an earning power assessment interview, the vocational expert shall disclose to the employee, in writing, the role and limits of the vocational expert's relationship with the employee.

(b) A vocational expert who conducts an earning power assessment interview shall generate a written initial report detailing the expert's involvement in the litigation and conclusions from the interview. The initial report need not contain the results or conclusions of any surveys or tests. The vocational expert shall serve a copy of the initial report on the employee and counsel, if known, within 30 days of the date of the interview.

(c) A vocational expert who authors additional written reports, including earning power assessments or labor market surveys, shall simultaneously serve copies of these written reports upon the employee and counsel, if known, when the expert provides the written reports to the insurer or its counsel.

(d) A vocational expert who satisfies the requirements of this section complies with the Code of Professional Ethics for Rehabilitation Counselors pertaining to the conduct of expert witnesses for purposes of section 306(b)(2) of the act (77 P. S. § 512(2)).

§ 123.205. Financial interest disclosure

(a) For the purposes of this section, a third-party administrator or another entity that performs services on behalf of an insurer, as specified in section 441(c) of the act (77 P. S. § 997(c)), is an insurer.

(b) Before an insurer refers an employee for an earning power assessment interview, the insurer shall disclose to the employee, in writing, any financial interest the insurer has with the person or entity conducting the earning power assessment interview.

SUBCHAPTER D. EARNING POWER DETERMINATIONS

§ 123.301. Employer job offer obligation

(a) For claims for injuries suffered on or after June 24, 1996, if a specific job vacancy exists within the usual employment area within this Commonwealth with the liable employer, which the employee is capable of performing, the employer shall offer that job to the employee prior to seeking a modification or suspension of benefits based on earning power.

(b) The employer's obligation to offer a specific job vacancy to the employee commences when the insurer provides the notice to the employee required by section 306(b)(3) of the act (77 P. S. § 512(b)(3)) and shall continue for 30 days or until the filing of a Petition for Modification or Suspension, whichever is longer. When an insurer files a Petition for Modification or Suspension which is not based upon a change in medical condition, the employer's obligation to offer a specific job vacancy commences at least 30 days prior to the filing of the petition.

(c) The employer's duty under subsections (a) and (b) may be satisfied if the employer demonstrates facts which may include the following:

(1) The employee was notified of a job vacancy and failed to respond.

(2) A specific job vacancy was offered to the employee, which the employee refused.

(3) The employer offered a modified job to the employee, which the employee refused.

(4) No job vacancy exists within the usual employment area.

(d) When more than one job which the employee is capable of performing becomes available, the employer maintains the right to select which job will be offered to the employee.

(e) The employer's duty under subsections (a) and (b) does not require the employer to hold a job open for a minimum of 30 days. Job offers shall be made consistent with the employer's usual business practice. If the making of job offers is controlled by the provisions of a collective bargaining agreement, the offer shall be made consistent with those provisions.

(f) If the employer has presented evidence that no job vacancy exists, the employee may rebut the employer's evidence by demonstrating facts which may include the following:

(1) During the period in which the employer has or had a duty to offer a specific job, the employer is or was actively recruiting for a specific job vacancy that the employee is capable of performing.

(2) During the period in which the employer has or had a duty to offer a specific job, the employer posted or announced the existence of a specific job vacancy, that the employee is capable of performing, which the employer intends to fill.

(g) A job may not be considered vacant if the employee's ability to fill the position was precluded by any applicable collective bargaining agreement.

§ 123.302. Evidence of earning power

For claims for injuries suffered on or after June 24, 1996, an insurer may demonstrate an employee's earning power by providing expert opinion evidence relative to the employee's capacity to perform a job. The evidence shall include job listings with agencies of the Department, private job placement agencies and advertisements in the usual employment area within this Commonwealth. Partial disability applies if the employe is able to perform his previous work, or can, considering the employe's residual productive skill, education, age and work experience, engage in any other kind of substantial gainful employment in the usual employment area in which the employe lives within this Commonwealth. If the employe does not live within this Commonwealth, the usual employment area where the injury occurred applies.

SUBCHAPTER E. COLLECTIVE BARGAINING

§ 123.401. Use of ADR systems

CBAs may provide for the use of an ADR system which may include arbitration, mediation and conciliation, for the resolution of claims for work-related injuries.

§ 123.402. Forms and filing requirements

(a) If the employer and the recognized or certified and exclusive representative of its employes agree to establish an ADR system, a copy of the portion of the CBA which establishes the ADR system shall be provided to the Governor's Office of Labor-Management Cooperation in the Department.

(b) The standard forms and filing requirements of the act which reflect the voluntary action or agreement of the parties remain in effect for parties participating in an ADR system under section 450 of the act (77 P. S. § 1000.6). The forms exclusively pertaining to filings before a workers' compensation judge are inapplicable to parties participating in an ADR system.

(c) Documents submitted to the Department under this subchapter shall clearly indicate, by notation on the top page of the document, that a section 450 ADR system governs the disposition of the matter.

(d) Final determinations rendered by means of an ADR system shall be documented and a copy of the determination shall be submitted to the parties and to the Department.

§ 123.403. Effect of creation, continuation and termination of ADR systems

(a) Once established by a CBA, an ADR system shall be the exclusive system for resolving claims for work-related injuries during the existence of the CBA or longer, if the CBA provides for the continued operation of the ADR system at the expiration of the CBA.

(b) When an ADR system governing a work-related injury is no longer in effect, resolution of claims shall be fully subject to the act, including review by a workers' compensation judge.

§ 123.404. Effect and appeal of ADR final determinations

(a) Final determinations rendered under an ADR system are binding and enforceable.

(b) Appeals from determinations rendered under an ADR system are limited to those made under the conditions specified by 42 Pa.C.S. § 7314 (relating to vacating award by court).

SUBCHAPTER F. EMPLOYE REPORTING AND VERIFICATION REQUIREMENTS

§ 123.501. Reporting requirement

An insurer shall notify the employe of the employe's reporting requirements under sections 204 and 311.1(a) and (d) of the act (77 P. S. §§ 71 and 631.1(a) and (d)). In addition, the insurer shall provide the employe with the forms required to fulfill the employe's reporting and verification requirements under section 311.1(d) of the act.

§ 123.502. Verification

(a) Insurers may submit Form LIBC-760, "Employee Verification of Employment, Self-employment or Change in Physical Condition," to the employe and employe's counsel, if known, to verify, no more than once every 6 months, that the status of the employe's entitlement to receive compensation has not changed.

(b) Form LIBC-760 shall be delivered to the employe in person or consistent with section 406 of the act.

(c) The employe shall complete and return form LIBC-760 to the insurer within 30 days of receipt of the form.

(d) If the employe fails to comply with subsection (c), the insurer may suspend payments of wage-loss benefits until Form LIBC-760 is returned by the employe.

(e) To suspend payments of compensation due to the employe's failure to comply with subsection (c), the insurer shall provide written notice to the employee, the employee's counsel, if known, and the Department, on Form LIBC-762, "Notice of Suspension for Failure to Return Form LIBC-760 (Employee Verification of Employment, Self-employment or Change in Physical Condition)" of the following:

(1) The workers' compensation benefits have been suspended because of the employee's failure to return the verification form within the 30-day statutorily prescribed time period.

(2) The workers' compensation benefits shall be reinstated by the insurer, effective upon receipt of the completed verification form.

(3) The employee has the right to challenge the suspension of benefits by filing a petition for reinstatement with the Department.

(f) Upon receipt of the completed verification form, the insurer shall reinstate the workers' compensation benefits for which the employee is eligible. The insurer shall provide written notice to the employee, employee's counsel, if known, and the Department, on Form LIBC-763, "Notice of Reinstatement of Workers' Compensation Benefits," that the employee's workers' compensation

benefits have been reinstated due to the return of the completed verification form. The notice shall further indicate the date the verification form was received by the insurer and the date of reinstatement of the workers' compensation benefits.

(g) Employees are not entitled to payments of workers' compensation during periods of noncompliance with subsection (c).

SUBCHAPTER G. INFORMAL CONFERENCE

§ 123.601. Representation of corporation at informal conference

Each party may be represented at the informal conference conducted under section 402.1 of the act (77 P. S. § 711.1), but the employer may only be represented by an attorney at the informal conference if the employee is also represented by an attorney. When the employee is not represented at the informal conference, an employer may be represented by an agent or other representative, other than an attorney, at the informal conference.

SUBCHAPTER H. USE OF OPTICALLY SCANNED DOCUMENTS

§ 123.701. Use of optically scanned documents

(a) The Bureau may optically scan original documents, or make other images or paper copies which accurately reproduce the originals, and may dispose of originals so copied.

(b) Copies made under this section, and certified by the custodian of records for the Bureau, are admissible in evidence in a proceeding with the same effect as though they were an original.

TITLE 34. LABOR AND INDUSTRY

PART VIII. BUREAU OF WORKERS' COMPENSATION

CHAPTER 125. WORKERS' COMPENSATION SELF-INSURANCE

SUBCHAPTER A. INDIVIDUAL SELF-INSURANCE

§ 125.1. Purpose

This subchapter is promulgated under section 435 of the act (77 P. S. § 991) to provide regulatory guidelines for the uniform and orderly administration of self-insurance for individual employers. This subchapter ensures full payment of compensation when due to employees of self-insured employers and to their dependents under the act and Occupational Disease Act.

§ 125.2. Definitions

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

Act — The Workers' Compensation Act (77 P. S. §§ 1 — 1041.4, 2501 — 2506 and 2701 — 2708).

Active self-insurer — A self-insurer that is not a runoff self-insurer.

Actuary — A member in good standing of the Casualty Actuarial Society or a member in good standing of the American Academy of Actuaries.

Adequate accident and illness prevention program — A determination by the Bureau under Chapter 129 (relating to workers' compensation health and safety) that a self-insured employer's accident and illness prevention services fulfill the program and service requirements as stated in that chapter.

Affiliates — Employers which are closely related through common ownership or control.

Aggregate excess insurance — Insurance under which the insurer pays on behalf of or reimburses a self-insurer for its payment of benefits on claims incurred during a policy period in excess of the retention amount to the insurer's liability limit.

Applicant — An employer requesting permission to initiate or to renew self-insurance, an employer requesting permission for it and its affiliates or subsidiaries to initiate or to renew self-insurance, or a parent company requesting permission for its subsidiaries to initiate or to renew self-insurance.

Authorized retention amount — A retention amount that is equal to or is less than a self-insurer's maximum quick assets exposure amount or the current standard retention amount, whichever is less, or the special retention amount approved by the Bureau.

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

Cash flow protection amount — The maximum amount of benefits a self-insurer pays over a 2-year period on an occurrence without reimbursement from an insurer under a specific excess insurance policy with a per year per occurrence cash protection plan.

(i) Catastrophic loss estimation — The greater of the following: The largest number of employees anticipated to work at one time during a work day at the largest location in this

Commonwealth in terms of the applicant's employment, or the employment of any of its affiliates or subsidiaries under a consolidated permit under § 125.4 (relating to application for affiliates and subsidiaries), multiplied by the current Statewide average weekly wage multiplied by 500.

(ii) The current Statewide average weekly wage multiplied by 5,000.

Claims service company — An individual, corporation, partnership or association engaged in the business of servicing a self-insurer's claims, including the adjusting and handling of claims, the payment of benefits and the provision of required reports.

Commonwealth — The term includes the following:

(i) The government of the Commonwealth, including the following:

(A) The courts and other officers or agencies of the unified judicial system.

(B) The General Assembly, and its officers and agencies.

(C) The Governor, and the departments, boards, commissions, authorities and officers and agencies of the Commonwealth.

(ii) An employer, politic and corporate, exercising an essential government function under the laws of the Commonwealth that is not a political subdivision.

Dedicated asset account — An account or fund, such as a bank, checking or trust account or an internal services fund, holding cash or investments solely to finance or hold reserves for the payment of a public employer's workers' compensation liability and related expenses.

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

Employer — An employer as defined in section 103 of the act (77 P. S. § 21) or under section 103 of the Occupational Disease Act (77 P. S. § 1203), or both.

Excess indemnity insurance — Aggregate excess insurance or specific excess insurance that meets the requirements in § 125.11(b)(1) (relating to excess insurance).

Excess insurance — Excess indemnity insurance or workers' compensation excess insurance.

Financial ability to self-insure — Possession of adequate financial capacity and adequate financial health, as specified in § 125.6(a) (relating to decision on application).

Guarantor — The affiliate or parent company that has guaranteed a self-insurer's liability by executing an agreement under § 125.4(b) that is on file with the Bureau.

Investment grade long-term credit or debt rating — A long-term credit or debt rating identified as investment grade by the NRSRO that issued it.

Liability limit — The maximum amount of benefits for which an insurer indemnifies a self-insurer under an excess insurance policy.

Long-term credit or debt rating — A measurement by an NRSRO of an applicant's willingness and intrinsic capacity to meet its long-term financial commitments as the commitments become due, exclusive

of the effects of any guaranties, insurance or other forms of credit enhancements or legal priorities on any of the applicant's financial obligations.

Loss development — The tendency of the cost of a group of claims to increase as they mature.

Maximum quick assets exposure amount — Five percent of an applicant's average year-end quick assets amount for its last 2 completed fiscal years.

Minimum funding amount — The lower of the following:

(i) The current Statewide average weekly wage multiplied by 500.

(ii) The retention amount of the applicant's current or any proposed excess insurance, if applicable.

Minimum security amount — The lower of the following:

(i) The current Statewide average weekly wage multiplied by 1,000.

(ii) The retention amount of the applicant's current or any proposed excess insurance, if applicable.

NRSRO — A designated Nationally-recognized statistical rating organization of the United States Securities and Exchange Commission or its successor.

Occupational Disease Act — The Pennsylvania Occupational Disease Act (77 P. S. §§ 1201 — 1603).

Parent company — An entity which directly or indirectly owns a majority of the voting stock of an employer or directly or indirectly controls a majority of the employer's board of directors appointments if the employer has no voting stock.

Permit — The document issued by the Bureau to an employer which authorizes the employer to operate as a self-insurer.

Political subdivision — A county, city, borough, incorporated town, township, school district, vocational school district and county institution district, municipal authority, or other entity created by a political subdivision under law.

Private employer — An employer who is not a public employer as defined in this section.

Public employer — The Commonwealth or a political subdivision.

Quick assets — The sum of an applicant's cash, cash equivalents, current receivables and marketable securities or, if the applicant is a public employer who uses fund accounting, the total of the applicant's general fund assets.

Retention amount —

(i) The maximum amount of benefits a self-insurer pays without reimbursement from the insurer under an aggregate excess insurance policy or under a specific excess insurance policy which does not include an annual cash flow protection plan.

(ii) The term also includes the lower of the maximum amount of benefits a self-insurer pays on each occurrence without reimbursement from the insurer or the cash flow protection amount under a specific excess insurance policy which includes an annual cash flow protection plan.

Runoff self-insurer — An employer that had been a self-insurer but no longer maintains a current permit.

Security — Surety bonds, letters of credit or cash or negotiable government securities held in trust to be used for the payment of a self-insurer's workers' compensation liability upon order of the Bureau if the self-insurer fails to pay its liability due to its financial inability or due to the self-insurer filing for bankruptcy or being declared bankrupt or insolvent.

Self-insurance — The privilege granted to an employer which has been exempted by the Bureau from insuring its liability under section 305(a) of the act (77 P. S. § 501(a)) and section 305 of the Occupational Disease Act (77 P. S. § 1405).

Self-insurance loss portfolio transfer policy — A policy of insurance accepted by the Bureau as meeting the requirements of § 125.21 (relating to self-insurance loss portfolio transfer policy) under which a self-insurer transfers liability incurred as a self-insurer to a workers' compensation insurer.

Self-insurer —

(i) An employer which has been granted the privilege to self-insure its liability and to maintain direct responsibility for the payment of this liability under the act and the Occupational Disease Act.

(ii) The term includes a parent company or affiliate which has assumed a subsidiary's or an affiliate's liability upon the termination of the parent-subsidiary or affiliate relationship.

Special retention amount —

(i) A retention amount that exceeds the applicant's maximum quick assets exposure amount or the standard retention amount requested by the applicant and approved by the Bureau based on a determination that the applicant has sufficient quick assets to easily liquidate all losses at the requested greater retention amount.

(ii) Additionally, an applicant whose self-insurance status began before September 11, 2010, may use a special retention amount that is equal to the retention amount of the applicant's excess insurance in effect on September 11, 2010.

Specific excess insurance — Insurance under which the insurer pays on behalf of or reimburses a self-insurer for its payment of benefits on each occurrence in excess of the retention amount to the insurer's liability limit.

Standard retention amount —

(i) The current Statewide average weekly wage multiplied by 500.

(ii) Rounded upward to the nearest hundred thousand.

Statewide average weekly wage — The amount calculated and reported by the Bureau under section 105.1 of the act (77 P. S. § 25.1).

Subsidiary — An employer whose voting stock or board of directors appointments are directly or indirectly controlled by a parent company.

Workers' compensation excess insurance — Aggregate excess insurance or specific excess insurance that meets the requirements n § 125.11(b)(2).

Workers' compensation excess insurance recoveries — Payments made to a self-insurer under a policy of workers' compensation excess insurance or payments receivable under a policy of worker's compensation excess insurance that the insurer has agreed in writing that it is liable to pay.

Workers' compensation insurer — An insurance company authorized to transact the class of insurance listed in section 202(c)(14) of The Insurance Company Law of 1921 (40 P. S. § 382(c)(14)).

§ 125.3. Application

(a) An applicant shall file an application on a form prescribed by and available upon request from the Bureau. All questions on the application shall be answered completely and accurately with the most recent information available. A rider may be attached if more space is necessary. The application shall be signed by the applicant, or if a corporation, an officer of the corporation. The application, including any attached riders and applicable forms, shall be verified as set forth on the application, subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities).

(b) Initial applications shall be filed with the Bureau no later than 3 months prior to the requested effective date of self-insurance. Renewal applications shall be filed with the Bureau no later than 3 months prior to the expiration of the current permit.

(c) With the application, the applicant shall include:

(1) The nonrefundable statutory fee in the amount of $500 for initial applicants or $100 for renewal applicants required under section 305(a) of the act (77 P. S. § 501(a)), payable to the "Commonwealth of Pennsylvania." A statutory fee is required in the amount of $500 for each affiliate or subsidiary being initially added or in the amount of $100 for each affiliate or subsidiary renewing under a consolidated application under § 125.4 (relating to application for affiliates and subsidiaries).

(2) Its Securities and Exchange Commission (SEC) Form 10-K, or equivalent form filed by a foreign corporation with the SEC or the governing body of an internationally recognized public securities exchange for an application being processed under the conditions of § 125.4(e), for the last complete fiscal year, if applicable. The filing of these forms does not serve as a substitute for the full completion of the application form.

(3) Its latest audited financial statements issued by a licensed certified public accountant or accounting firm. For a private employer, the audited financial statements must cover the last complete fiscal-year period immediately prior to the date of application. The audited financial statements must meet the following criteria:

(i) They must be presented in conformance with applicable generally accepted accounting principles as promulgated by the Financial Accounting Standards Board or the Government Accounting Standards Board or with international financial reporting standards promulgated by the International Accounting Standards Board. The text of the financial statements and their accompanying notes must be in the English language. If the currency used in the financial statements is not in United States dollars, the applicant shall cooperate and assist the Bureau in converting the currency to United States dollars.

(ii) They must be audited in accordance with generally accepted auditing standards in the United States or in accordance with the standards of the Public Company Accounting Oversight Board (United States) or the International Standards on Auditing. An

unqualified or qualified opinion shall be stated on the most recent audited financial statements.

(iii) If the most current audited period precedes the application date by more than 6 months, the applicant's latest SEC Form 10-Q, or similar form filed by a foreign corporation with the SEC or the governing body of an internationally recognized public securities exchange for an application being processed under the conditions of § 125.4(e), or unaudited interim financial statements must be submitted.

(4) Audited financial statements covering the applicant's second and third most recent complete fiscal-year periods prior to the date of the application, if an initial application. If audited financial statements covering those periods are not available, financial statements reviewed by a certified public accountant in accordance with standards established by the American Institute of Certified Public Accountants or the International Auditing and Assurance Standards Board covering the second and third most recent complete fiscal year periods prior to the date of the application will be accepted.

(5) A report of the paid and incurred workers' compensation loss experience in this Commonwealth under each of the 3 completed policy years prior to the application of each employer requesting self-insurance, if an initial application. The loss information for each policy year shall be valued witin3 months prior to the date of the submission of the application.

(6) A report on a form prescribed by the Bureau and provided to each employer requesting self-insurance stating the costs of claims incurred by the employer by annual periods and projecting the total value of its outstanding liability under the act and the Occupational Disease Act, if a renewal application. A renewal applicant that has retained the services of an actuary to project the total value of its outstanding liability may submit the actuary's report with its application.

(7) A report for each employer requesting self-insurance on a form prescribed by the Bureau and provided to each employer requesting self-insurance summarizing the existence of the accident and illness prevention program required under section 1001(b) of the act (77 P. S. § 1038.1) and regulations promulgated thereunder.

(8) A listing for each employer requesting self-insurance, in a Bureau-prescribed electronic format provided to each employer requesting self-insurance, of the employer's Pennsylvania workers' compensation claims incurred as a self-insurer, including claims currently in litigation, and information such as payments and reserves on each claim. The listing must include:

(i) All open claims at the time of submission.

(ii) All claims closed on or after September 11, 2010.

(iii) Case reserves provided in the listing must be established according to instructions on forms prescribed by the Bureau and provided to each employer requesting self-insurance.

(9) Written verification of the applicant's current long-term credit or debt ratings, if any.

(d) The applicant shall provide additional data, information and explanation that the Bureau deems pertinent to its review of the application based on the factors enumerated under § 125.6(a) (relating to decision on application), and shall make any corrections determined necessary by the Bureau, and provide any items under subsection (c) determined missing or insufficient by the Bureau. The

applicant shall provide the data, information, explanation, corrections or missing items within 21 days of its receipt of written notification from the Bureau of its need to do so, or by a later date if requested by the applicant and approved by the Bureau. If the applicant does not provide the data, information, explanation, corrections or missing items within the prescribed time period, the application will be deemed withdrawn. A renewal applicant that does not provide the data, information, explanation, corrections or missing items within the prescribed time period shall obtain workers' compensation insurance coverage effective the expiration of that time period and shall provide evidence of the coverage, such as a certificate of insurance, to the Bureau no later than the coverage's effective date.

(e) The Bureau will not issue a decision on the application under § 125.6 until the application, including all items required under subsection (c) and all additional data, information, explanation and corrections under subsection (d), have been submitted.

(f) An initial applicant's requested self-insurance effective date is subject to the approval of the Bureau. An initial applicant which fails to insure its liability pending review of its application will be subject to prosecution under the act and the Occupational Disease Act.

§ 125.4. Application for affiliates and subsidiaries

(a) An affiliate or subsidiary may be included under an application submitted by another affiliate or its parent company by providing information and data on the affiliate or subsidiary on a separate form prescribed by and available upon request from the Bureau. The related entities will be included under one consolidated permit if the application is approved. A written notification shall be provided by the applicant to delete an affiliate or a subsidiary from a consolidated permit after its issuance.

(b) An applicant shall provide a written agreement adopted by its board of directors on a form prescribed by the Bureau which states that the applicant guarantees the payment of all claims incurred by the affiliates or subsidiaries. The applicant shall further assume liability for the payment of an affiliate's or subsidiary's claims incurred during its period of self-insurance upon termination of the affiliate or parent-subsidiary relationship unless the applicant is relieved of this liability by the Bureau. In determining whether to relieve an applicant of a subsidiary's or affiliate's liability, the Bureau will consider, among other things, the financial ability of the new owner of the subsidiary or affiliate to pay the liabilities, the new owner's credit worthiness and the adequacy of security held by the Bureau covering the liability.

(c) The guarantor may not terminate the agreement under any circumstances without first giving the Bureau and the affected affiliate or subsidiary 45 days written notice. The affiliate's or subsidiary's self-insurance status automatically terminates upon expiration of the 45-day notice period.

(d) Except as provided in § 125.4(e), if an affiliate or subsidiary not included under a consolidated application as outlined in subsection (a) wishes to self-insure, it shall submit an application in its own name and provide its own audited financial statements in the manner indicated in § 125.3 (relating to application). The Bureau may require the parent company to furnish appropriate financial information within 21 days of its receipt of written notification from the Bureau of its need to do so, or by a later date if requested by the applicant and approved by the Bureau.

(e) If the applicant is a subsidiary of a parent company that is not incorporated or organized under the laws of a state of the United States, the applicant may submit its parent company's consolidated audited financial statements and an unaudited consolidated balance sheet of the applicant's financial condition, or other financial information on the applicant that the Bureau deems pertinent to its review of the application, to satisfy the financial reporting requirements of § 125.3(c), provided the parent company's audited financial statements comply with § 125.3(c)(3)(i) and (ii).

§ 125.5. Preliminary requirements

(a) An applicant shall have been in business for at least 3 consecutive years prior to application.

(b) An applicant shall be incorporated or organized under the laws of a state of the United States.

(c) Each employer requesting self-insurance shall have an adequate accident and illness prevention program.

§ 125.6. Decision on application

(a) The application of an applicant which meets the requirements of § 125.5 (relating to preliminary requirements) will be approved if the Bureau determines that the applicant has demonstrated that it possesses the financial ability to self-insure.

(1) An applicant shall demonstrate that it has adequate financial capacity by showing one of the following:

(i) The retention amount of the applicant's current or proposed excess insurance equals or is less than its authorized retention amount.

(ii) The applicant's catastrophic loss estimation is equal to or is less than its maximum quick assets exposure amount.

(2) An applicant shall demonstrate that it has adequate financial health, as follows:

(i) If a public employer, the applicant satisfies or will satisfy the requirements established for it under § 125.10 (relating to funding by public employers).

(ii) If a private employer, the applicant's level of financial stability, solvency and liquidity is such that it satisfies one of the following:

(A) The applicant, or its parent company for an application being processed under the conditions of § 125.4(e) (relating to application for affiliates and subsidiaries), possesses an investment-grade long-term or debt rating, or such a rating that is one generic rating classification below investment grade.

(B) For an applicant who does not receive a long-term credit or debt rating by an NRSRO, or whose parent company does not receive a long-term credit or debt rating by an NRSRO for an application being processed under the conditions of § 125.4(e), the Bureau estimates that the applicant, or its parent company for an application being processed under the conditions of § 125.4(e), would merit an investment grade long-term credit or debt rating, or a rating that is one generic rating classification below investment grade, if it were rated.

(C) An applicant that was approved to self-insure as of September 11, 2010, that possesses an actual or Bureau-estimated long-term credit or debt rating more than one generic rating classification below investment grade shall be deemed to possess adequate financial health if its generic rating does not decline further. This clause will no longer apply if the applicant's actual or Bureau-estimated long-term credit or debt rating subsequently increases to one generic rating classification below investment grade or higher.

(b) The Bureau will consider the following information in assessing an applicant's financial ability to self-insure:

(1) The applicant's level of financial health, or its parent company's level of financial health for an application being processed under the conditions of § 125.4(e), based upon the applicant's or its parent's long-term credit or debt rating, if any, or upon an evaluation by the Bureau of one or more of the following:

(i) The applicant's financial statements, or its parent company's financial statements for an application being processed under the conditions of § 125.4(e), which may include comparisons of the applicant's or its parent company's financial ratios to general or to industry ratios and cash flow analysis.

(ii) Public documents and reports filed with other state and Federal agencies including the United States Securities and Exchange Commission.

(iii) Other financial analysis information provided to or considered by the Bureau, including financial analysis comparison databases and evaluation models.

(2) The amount of the applicant's quick assets at the end of its last 2 completed fiscal years as shown on the financial statements provided to the Bureau under § 125.3(c) (relating to application) or under § 125.4(e).

(3) The terms, conditions and limits of the applicant's existing or proposed excess insurance.

(4) For a public employer, its ability to satisfy or its past history in satisfying the requirements established under § 125.10.

(c) If the Bureau finds under subsection (a) that the applicant possesses the financial ability to self-insure, it will send to the applicant an initial decision approving the application and a list of conditions as set forth under subsection (c)(2) that must be met before the applicant will be issued a permit. The Bureau will issue a permit to a renewal applicant at the time of the initial decision when the renewal applicant is currently in compliance with the conditions set forth by the Bureau.

(1) An applicant has 45 days from the receipt of the initial decision approving the application to comply with the conditions set forth by the Bureau.

(i) The applicant may toll the 45-day compliance period by filing a request for a conference or notification of its intent to submit additional written information under subsection (e).

(ii) An applicant may be granted a 30-day extension to meet the conditions if the applicant requests an extension in writing. The Bureau must receive the extension request within the initial 45-day compliance period.

(iii) Unless a timely reconsideration is initiated under subsection (e), when the applicant does not meet the conditions within this compliance period, the application will be deemed denied.

(iv) A renewal applicant that does not meet the conditions within this compliance period and that has not timely initiated the procedures outlined in subsection (e) shall obtain workers' compensation insurance coverage effective the expiration date of the

compliance period and provide evidence of the coverage, such as a certificate of insurance, to the Bureau no later than the coverage's effective date.

(2) The applicant will be issued a permit after all of the following have been filed with the Bureau:

(i) Security in an amount as set forth in § 125.9 (relating to security requirements) or funding as set forth in § 125.10.

(ii) A certificate providing evidence that the applicant has obtained excess insurance coverage with limits set forth under § 125.11(a) (relating to excess insurance), if required.

(iii) A guarantee agreement executed by its parent company or an affiliate as set forth in § 125.4, if required.

(iv) Contact information on the claims service company or in-house staff that will be handling the applicant's claims.

(v) Documents relating to any other requirement set by the Bureau to protect the compensation rights of employees.

(d) If an applicant does not meet the requirements of § 125.5 or if upon review under subsection (a) the Bureau finds that the applicant has not demonstrated that it possesses the financial ability to self-insure, the Bureau will send to the applicant an initial decision denying the application. The initial decision will state the documents, data, information, explanation and corrections received from the applicant or otherwise reviewed or considered by the Bureau in rendering its initial decision. A renewal applicant shall obtain workers' compensation insurance coverage effective no later than 30 days after its receipt of an initial decision denying the renewal application and shall provide evidence of the coverage, such as a certificate of insurance, to the Bureau no later than the coverage's effective date, unless the applicant has timely initiated the procedures outlined in subsection (e).

(e) The applicant may request a conference with the Bureau to submit additional materials to support its application or the alteration of the conditions required in the initial decision, or to challenge the accuracy of underling calculations made or data considered by the Bureau in its decision or conditions. The applicant may also notify the Bureau of its intention to submit these materials directly in writing without a conference. The Bureau must receive a request or notification within 20 days of the date of the Bureau's initial decision.

(1) Upon its receipt of the request or notification, the Bureau will schedule a conference. If a conference is not requested, the applicant shall provide the additional materials within 21 days of its receipt of written notification from the Bureau of its need to do so, or by a later date if requested by the applicant and approved by the Bureau.

(2) The prior permit of a renewal applicant that has filed a timely request for a conference or notification of intent to submit additional materials will be automatically extended beyond the permit's original expiration date until the Bureau issues a reconsideration decision on the renewal application under subsection (f). During the time the permit is extended, the prior conditions established by the Bureau, as set forth under subsection (c)(2), shall continue to apply.

(f) After a conference or the receipt of additional materials, the Chief of the Self-Insurance Division of the Bureau will review the entire record of the application and will issue a reconsideration decision on the application.

(1) The applicant shall have 30 days from its receipt of a reconsideration decision approving an application to comply with any conditions set forth by the Bureau in that decision.

(i) Unless a timely appeal is filed under subsection (g), when the applicant does not meet the conditions within this 30-day period, the application will be deemed denied.

(ii) A renewal applicant that does not meet the conditions within this 30-day period shall obtain workers' compensation insurance coverage effective the expiration of the compliance period and shall provide evidence of the coverage, such as a certificate of insurance, to the Bureau no later than the coverage's effective date, unless the applicant has timely initiated the procedures outlined in subsection (g).

(2) Upon the issuance of a reconsideration decision denying a renewal application, the renewal applicant shall obtain workers' compensation insurance coverage effective no later than 30 days after its receipt of the reconsideration decision and provide evidence of the coverage, such as a certificate of insurance, to the Bureau no later than the coverage's effective date unless the applicant has timely initiated the procedures outlined in subsection (g).

(g) An applicant shall have the right to appeal a reconsideration decision issued under subsection (f). The Bureau must receive the appeal within 30 days of the date of the reconsideration decision. The prior permit of a renewal applicant that filed a timely appeal shall be automatically extended beyond the permit's original expiration date, until a presiding officer issues a written decision on the appeal. During the time the permit is extended, the prior conditions established by the Bureau, as set forth under subsection (c)(2), shall continue to apply. Untimely appeals will be dismissed without further action by the Bureau.

(1) The Director of the Bureau will assign the appeal to a presiding officer who will schedule a hearing on the appeal from the reconsideration decision. The presiding officer will provide notice to the parties of the hearing date, time and place.

(2) The hearing will be conducted under this subsection and 1 Pa. Code Part II (relating to General Rules of Administrative Practice and Procedure) to the extent not superseded in paragraph (6). The presiding officer will not be bound by strict rules of evidence.

(3) Hearings will be stenographically-recorded. The transcript of the proceedings will be part of the record.

(4) The presiding officer will issue a written decision and order under 1 Pa. Code Chapter 35, Subchapters G and H (relating to proposed reports; and agency action) to the extent not superseded in paragraph (6). The presiding officer will determine whether the Bureau abused its discretion or acted arbitrarily in the reconsideration decision. The applicant has the burden to prove that the Bureau abused its discretion or acted arbitrarily in the reconsideration decision.

(5) A party aggrieved by a decision rendered by the presiding officer may appeal the decision to Commonwealth Court.

(6) This subsection supersedes 1 Pa. Code §§ 35.131, 35.190, 35.201, 35.211 — 35.214 and 35.221.

(h) An applicant which has been denied self-insurance may reapply after audited financial statements are published subsequent to the latest ones submitted with the denied application.

§ 125.7. Permit

(a) A permit is issued for 1 year, except that the Bureau may shorten or extend the effective period of a permit by not more than 6 months to facilitate the filing of timely financial statements or other data and information required with the next renewal application.

(b) If the Bureau fails to issue an initial decision with respect to a renewal application under § 125.6 (relating to decision on application) prior to the expiration of the permit for the prior year, the prior permit will be automatically extended under the prior conditions as set forth under § 125.6(c)(2) beyond the permit's original expiration date, until a decision on the renewal application is issued by the Bureau. This automatic extension applies only in cases when the renewal application has been timely filed under § 125.3 (relating to application) and the applicant has submitted or is submitting all data, information, explanation, corrections and missing items, or has corrected or is correcting inaccurate data, within the time period prescribed in writing by the Bureau.

(c) If a renewal applicant's permit for the prior year expires while the applicant is in the process of satisfying conditions set forth in an initial or reconsideration decision, the prior permit will be automatically extended beyond its original expiration date, pending satisfaction of the conditions within the time period set forth under the applicable provisions of § 125.6.

§ 125.8. [Reserved]

§ 125.9. Security requirements

(a) A private employer shall provide security in an amount as set forth in subsection (d). The security required in this section is not a substitute for the applicant demonstrating its financial ability to self-insure. A self-insurer's security may be adjusted annually or more frequently as determined by the Bureau.

(b) The following forms of security are acceptable:

(1) A surety bond on a form prescribed by and available upon request from the Bureau issued by a company authorized to transact surety business in this Commonwealth by the Insurance Department.

(i) At the time of the issuance of the bond, the surety company shall possess a current A. M. Best Rating of A- or better or a Standard & Poor's insurer's financial strength rating of A or better or a comparable rating by another NRSRO.

(ii) The self-insurer shall replace the bond with a new bond issued by a surety company with an acceptable rating or with another acceptable form of security if the surety company's highest rating falls below an A. M. Best Rating of B+, a Standard & Poor's insurer's financial strength rating of A- or a comparable rating by another NRSRO after the bond is issued. If the bond is not replaced within 45 days of the self-insurer's receipt of written notification of the rating decline from the Bureau, the Bureau will have discretion to draw on the surety bond and deposit the proceeds with the State Treasurer to secure the self-insurer's liability and to revoke the current permit if the bond exclusively secures claims currently being incurred against the self-insurer.

(iii) An active self-insurer that does not post another bond or another acceptable form of security to cover claims currently being incurred against the self-insurer, after the surety of a bond that exclusively secures the claims provides notification of its intention to terminate the bond, shall obtain workers' compensation insurance coverage effective the bond's termination date. The self-insurer shall provide evidence of the coverage, such as a certificate of insurance, to the Bureau no later than the coverage's effective date.

(2) A security deposit held under a trust agreement prescribed by and available upon request from the Bureau and maintained for the benefit of employees of the self-insurer:

(i) The deposit must consist of cash; bonds or other evidence of indebtedness issued, assumed or guaranteed by the United States of America, or by an agency or instrumentality of the United States; investments in common funds or regulated investment companies which invest primarily in United States Government or Government agency obligations; or bonds or other security issued by the Commonwealth and backed by the Commonwealth's full faith and credit.

(ii) The securities must be held in a Commonwealth chartered bank and trust company or trust company as defined in section 102 of the Banking Code of 1965 (7 P. S. § 102) or a Federally-chartered bank or foreign bank with a branch office and trust powers in this Commonwealth.

(3) An irrevocable letter of credit using language required by the Bureau issued by and payable at a branch office of a commercial bank located in the continental United Sates. The letter of credit must state that the terms of the letter of credit automatically renew annually unless the letter of credit is specifically nonrenewed by the issuing bank 60 days or more prior to the anniversary date of its issuance.

(i) At the time of issuance of the letter of credit, the issuing bank or its holding company shall have a B/C or better rating or 2.5 or better credit evaluation score by Fitch Ratings, as successor to the rating services of Thomson Bank Watch, or the issuing bank shall have a CD or long-term issuer credit rating of BBB or better or a short-term issuer credit rating of A-2 or better by Standard & Poor's or a comparable rating by another NRSRO.

(ii) The self-insurer shall replace the letter of credit with a new letter of credit issued by a bank with an acceptable credit rating or with another acceptable form of security if the issuing bank's highest rating falls below the acceptable rating outlined in subparagraph (i) after the letter of credit is issued. If the letter of credit is not replaced within 45 days, the Bureau will draw on the letter of credit and will deposit the proceeds to secure the self-insurer's liability.

(c) Affiliates included under a consolidated permit under § 125.4(a) (relating to application for affiliates and subsidiaries) must be included together under the forms of security provided. For purposes of this section, affiliates that are runoff self-insurers are considered to be active self-insurers if they were included under a consolidated permit with affiliates that remain active self-insurers.

(d) The amount of security required of private employers is determined as set forth in paragraphs (1) — (6).

(1) For a new self-insurer, the Bureau will determine the initial amount of security, to be calculated as follows:

(i) An amount no less than two times the amount of the applicant's total greatest annual insured incurred workers' compensation losses in this Commonwealth during the last 3 completed policy years prior to its application, or the minimum security amount, whichever is greater.

(ii) Discounted by the percentage outlined under subsection (1) for the applicant's highest current long-term credit or debt rating, if any.

(iii) Rounded upward to the nearest hundred thousand.

(2) For those active self-insurers who have been approved to self-insure for more than 1 year but less than 3 years, the amount of security is calculated as follows:

(i) The greater of:

(A) The amount outlined in paragraph (1).

(B) One hundred percent of the Bureau's calculation of the self-insurer's undiscounted outstanding liability based on loss development, net of workers' compensation excess insurance recoveries.

(ii) Discounted by the percentage outlined under subsection (1) for the applicant's highest current long-term credit or debt rating, if any.

(iii) Rounded upward to the nearest hundred thousand.

(3) For those active self-insurers who have been approved to self-insure for 3 or more years, the amount of security is calculated as follows:

(i) One hundred percent of the Bureau's calculation of the self-insurer's undiscounted outstanding liability based on loss development, net of workers' compensation excess insurance recoveries, or the minimum security amount, whichever is greater.

(ii) Discounted by the percentage outlined under subsection (1) for the applicant's highest current long-term credit or debt rating, if any.

(iii) Rounded upward to the nearest hundred thousand.

(4) When multiple affiliates are included under a consolidated permit, the required amount of security for the consolidated program is calculated as follows:

(i) The sum of each individual affiliate's required amount of security as calculated under the applicable paragraphs above but excluding the effects of any rounding or minimum applicable to the individual affiliates, or the minimum security amount, whichever is greater.

(ii) Discounted by the percentage outlined under subsection (1) for the applicant's highest current long-term credit or debt rating, if any.

(iii) Rounded upward to the nearest hundred thousand.

(5) For runoff self-insurers, the amount of security is calculated as follows:

(i) One hundred percent of the Bureau's calculation of the runoff self-insurer's undiscounted outstanding liability based on loss development, net of workers' compensation excess insurance recoveries.

(ii) Discounted by the percentage outlined under subsection (1) for the runoff self-insurer's or its guarantor's highest current long-term credit or debt rating, if any.

(iii) Rounded upward to either:

(A) The nearest ten thousand if the Bureau's calculated undiscounted outstanding liability, net of workers' compensation excess insurance recoveries, discounted by the percentage outlined under subsection (1) for the runoff self-insurer's or its guarantor's highest current long-term credit or debt rating, if any, is $50,000 or less.

(B) The nearest hundred thousand.

(6) When multiple runoff self-insurers are included under one security instrument, the required amount of security is calculated as follows:

(i) The sum of each individual runoff self-insurer's required amount of security as calculated under paragraph (5) but excluding the effects of any rounding applicable to the individual runoff self-insurers.

(ii) Discounted by the percentage outlined under subsection (1) for the runoff self-insurers' or their guarantor's highest current long-term credit or debt rating, if any.

(iii) Rounded upward to either:

(A) The nearest ten thousand if the Bureau's calculated undiscounted outstanding liability, net of workers' compensation excess insurance recoveries, discounted by the percentage outlined under subsection (1) for the runoff self-insurers' or their guarantor's highest current long-term credit or debt rating, if any, is $50,000 or less.

(B) The nearest hundred thousand.

(e) A self-insurer wishing to refute the Bureau's adjustment of its outstanding liability by its history of loss development may do so by providing a report prepared by an actuary.

(f) The Bureau will incorporate the overall Pennsylvania workers' compensation experience of insured or self-insured employers in the self-insurer's industry or of all insured or self-insured employers in its selection of loss development factors under subsection (d) if the claim volume or experience of the self-insurer is not sufficient to be considered fully credible based on generally accepted actuarial procedures. The loss development factors selected by the Bureau and its other judgments in its calculation of a self-insurer's outstanding liability will be sufficiently conservative to ensure the adequate provision of security.

(g) The Bureau will make adjustments to the loss development procedures under subsection (d) it deems appropriate under the circumstances if the Bureau believes that a self-insurer has changed its reserving methodology in such a way as to invalidate loss development factors based on past experience.

(h) The Bureau may reduce the amount of security required of a self-insurer under subsection (d) if the self-insurer confirms that liabilities under the act and the Occupational Disease Act are funded through a Black Lung Benefits Trust established under section 501(c)(21) of the Internal Revenue Code of 1986 (26 U.S.C.A. § 501(c)(21)).

(i) The Bureau may reduce the amount of security required of a self-insurer under subsection (d) to no less than the minimum security amount rounded upward to the nearest hundred thousand if the self-insurer establishes a funding trust to provide a source of funds for the payment of its liability. A self-insurer may elect to establish a funding trust or it may be required by the Bureau to establish a funding trust where the Bureau determines that a dedicated source of funds is needed to further ensure the timely payment of the self-insurer's liability. In either case, the following conditions shall be met:

(1) The trust agreement must be in a form prescribed by the Bureau.

(2) The trust assets must be held in a Commonwealth chartered bank and trust company or trust company as defined in section 102 of the Banking Code of 1965 or a Federally chartered bank or foreign bank with a branch office and trust powers in this Commonwealth.

(3) The value of the trust fund must be adjusted at least annually to the required funding level as determined by the Bureau.

(j) A self-insurer with security which is less than the level of security required under subsection (d) may be permitted to phase in the level of required security over a maximum of 2 years. The Bureau will determine the terms of the phase-in period, including the length of time and the annual phase-in amounts.

(k) The Bureau may release a runoff self-insurer of its obligation to provide security if either of the following occurs:

(1) The runoff self-insurer provides evidence that its liability was assumed under a self-insurance loss portfolio transfer policy.

(2) If the runoff self-insurer made no payments on its liability over the past 2 years and all claims against the runoff self-insurer are closed.

(l) The following discount percentages shall be applied in calculating a self-insurer's required amount of security under subsection (d) based on the highest current long-term credit or debt rating of the self-insurer or of its guarantor:

SECURITY DISCOUNT TABLE

Moody's Investors Service	*Standard & Poor's, Fitch Ratings, or Dominion Bond Rating Service*	*Security Discount*
Aaa	AAA	75%
Aa1	AA+	65%
Aa2	AA	60%
Aa3	AA-	55%
A1	A+	45%
A2	A	40%
A3	A-	35%
Baa1	BBB+	25%
Baa2	BBB	20%
Baa3	BBB-	15%
Ba1 and lower	BB+ and lower	0%

(m) The Bureau may revise the table in subsection (1) through publication of a notice in the *Pennsylvania Bulletin* to assign security discount rates for any organization receiving designation as a NRSRO after September 11, 2010.

§ 125.10. Funding by public employers

(a) A self-insured public employer shall establish and maintain a dedicated asset account to provide a source of funds for the payment of benefits and other obligations and expenses relating to its self-insurance program. This section does not apply to a runoff self-insured public employer whose average annual payout of benefits on self-insurance claims over its last 3 completed fiscal years, net of workers' compensation excess insurance recoveries, is less than the current Statewide average weekly wage multiplied by 100.

(b) For a new self-insured public employer and for an active self-insured public employer that has been self-insured for less than 3 consecutive years, the required asset level of the dedicated asset account established under subsection (a) is calculated as follows:

(1) An amount greater than or equal to 20% of the public employer's modified manual premium calculated in accordance with § 125.202 (relating to definitions) or the minimum funding amount, whichever is greater.

(2) Discounted by the percentage outlined under § 125.9(1) (relating to security requirements) for the self-insurer's highest current long-term credit or debt rating, if any.

(3) The dedicated asset account must equal the above prescribed asset level no later than 30 days before the effective date of the public employer's initial permit and may not be reduced below this asset level for the first 3 years of self-insurance.

(c) For an active self-insured public employer that has been self-insured for more than 3 consecutive years but less than 7 consecutive years, the required asset level of the dedicated asset account established under subsection (a) is calculated as follows:

(1) An amount greater than or equal to the greater of the following:

(i) The self-insurer's greatest annual fiscal year payout of benefits since its initial approval to self-insure, net of workers' compensation excess insurance recoveries, plus 20% of that annual payment amount.

(ii) The minimum funding amount.

(2) Discounted by the percentage outlined under § 125.9(1) for the self-insurer's highest current long-term credit or debt rating, if any.

(3) The dedicated asset account must be equal to or exceed the prescribed asset level 120 days before the beginning of the self-insurer's next fiscal year or by a later date if requested by the applicant and approved by the Bureau.

(4) Prior to issuing a permit under § 125.6(c) (relating to decision on application), the Bureau will require that the asset level of a self-insurer's dedicated asset account under paragraphs (1) and (2) be based on an adjustment to the self-insurer's greatest annual benefit payout amount to correct any material underpayment of benefits the Bureau believes is the result of the self-insurer's failure to pay compensation for which it is liable during the evaluation period.

(d) For an active self-insured public employer that has been self-insured for 7 or more consecutive years, the required asset level of the dedicated asset account established under subsection (a) is calculated as follows:

(1) An amount greater than or equal to the greater of the following:

(i) The self-insurer's average annual payout of benefits over its three most recent completed fiscal years, net of workers' compensation excess insurance recoveries, plus 20% of that average payment amount.

(ii) The minimum funding amount.

(2) Discounted by the percentage outlined under § 125.9(1) for the self-insurer's highest current long-term credit or debt rating, if any.

(3) If the asset level of the self-insurer's dedicated asset account is below the required level under paragraphs (1) and (2) as of September 11, 2010, the required asset level of the account established under subsection (a) is calculated as follows:

(i) The amount required to be in the dedicated asset account under paragraphs (1) and (2) for the current year.

(ii) Minus the difference between the amount required to be in the dedicated asset account under paragraphs (1) and (2) as of September 11, 2010, and the actual asset value of the dedicated asset account as of September 11, 2010.

(4) The dedicated asset account must equal or exceed the prescribed asset level 120 days before the beginning of the self-insurer's next fiscal year or by a later date if requested by the applicant and approved by the Bureau.

(5) Prior to issuing a permit under § 125.6(c), the Bureau will require that the asset level of a self-insurer's dedicated asset account under paragraphs (1) and (2) be based on an adjustment to the self-insurer's average annual payout of benefits to correct any material underpayment of benefits the Bureau believes is the result of the self-insurer's failure to pay compensation for which it is liable during the evaluation period.

(e) For a runoff self-insured public employer, the asset level of the dedicated asset account established under subsection (a) is that outlined under subsection (d), except that the minimum funding amount does not apply.

(f) If a self-insured public employer does not possess an investment grade long-term credit or debt rating, the Bureau may require that the asset level of its dedicated asset account established under subsection (a) be greater than that outlined under subsection (b), (c) or (d), in any amount which the Bureau determines will guaranty that the self-insurer will have sufficient funding to meet its claims payments and other obligations and expenses relating to its self-insurance program as they come due over the self-insurer's next fiscal year.

§ 125.11. Excess insurance

(a) An applicant whose catastrophic loss estimation is greater than its maximum quick assets exposure amount shall obtain aggregate excess insurance or specific excess insurance with a retention amount that is no more than its authorized retention amount and a liability limit acceptable to the Bureau to provide an adequate level of protection to cover the losses from a catastrophic event. The Bureau

will consider the financial capacity of the applicant and the amount of the catastrophic loss estimation in determining the adequacy of the applicant's proposed liability limit.

(b) A contract or policy of excess insurance must comply with the following:

(1) For excess indemnity insurance:

(i) It must state that it is not cancelable or nonrenewable unless written notice by registered or certified mail is given to the other party to the policy and to the Bureau at least 45 days before termination by the party desiring to cancel or not renew the policy.

(ii) It must state that it applies to any losses of a self-insurer under the act or the Occupational Disease Act.

(iii) It may not exclude coverage for any categories of injuries or diseases compensable under the act and the Occupational Disease Act.

(iv) It must be issued by an insurer that possesses an A. M. Best rating of A- or better, or a Standard & Poor's insurer financial strength rating of A or better, or a comparable rating by another NRSRO.

(2) For workers' compensation excess insurance:

(i) It must meet the requirements of paragraph (1)(i) — (iii).

(ii) It must state that if a self-insurer is unable to make benefit payments under the act and the Occupational Disease Act due to insolvency or bankruptcy, the excess carrier shall make payments to other parties involved in the paying of the self-insurer's liability, as directed by the Bureau, subject to the policy's retentions and limits.

(iii) It must state that the following apply toward reaching the retention amount in the excess contract:

(A) Payments made by the employer.

(B) Payments made on behalf of the employer under a surety bond or other forms of security as required under this subchapter.

(C) Payments made by the Self-Insurance Guaranty Fund.

(iv) It must be issued by a workers' compensation insurer that includes the premium collected for the insurance in data used by the Worker' Compensation Security Fund set forth in the Workers' Compensation Security Fund Act (77 P. S. §§ 1051 — 1066) to calculate assessments against workers' compensation insurers to finance the operations of that fund.

(c) A certificate of the excess insurance obtained by the self-insurer must be filed with the Bureau together with a certification that the policy fully complies with subsection (b).

§ 125. 12. Payment, handling and adjusting of claims

(a) A self-insurer and its claims service company are responsible for the prompt payment of compensation in accordance with the act, the Occupational Disease Act and this part.

(b) A self-insurer shall have ample facilities and competent personnel within its organization to service its program of claims handling and adjusting or shall contract with a registered claims service company to provide these services.

(c) A self-insurer shall immediately notify the Bureau when it changes arrangements for the handling or adjusting of its claims, including the initiation, modification or termination of self-administration arrangements or the initiation, termination, expiration or modification of services with a registered claims services company. The self-insurer shall file with the Bureau a summary of data on its claims, such as cumulative payments sorted by year of loss, in a format prescribed by the Bureau and provided to the self-insurer within 21 days of its receipt of written notification from the Bureau of its need to do so.

§ 125.13. Special funds assessments

(a) A self-insurer is responsible for the payment of assessments to maintain funds under the act, including:

(1) The Workmen's Compensation Administration Fund.

(2) The Subsequent Injury Fund.

(3) The Workmen's Compensation Supersedeas Fund.

(4) The Self-Insurance Guaranty Fund.

(5) The Uninsured Employers Guaranty Fund.

(b) A runoff self-insurer is liable for the payment of any assessments made after the termination or revocation of its self-insurance status until it has discharged the obligations to pay compensation which arose during the period of time it was self-insured. The assessments of a runoff self-insurer shall be based on the payment of claims that arose during the period of its self-insurance status.

(c) A self-insurer shall keep accurate records of compensation paid on a calendar year basis, including payment for disability of all types, death benefits, medical benefits and funeral expenses, for the purposes of assessments under the act and the Occupational Disease Act. The records must be available for audit or physical inspection by Bureau employees or other designated persons, whether in the possession of the self-insurer or a service company. If the Bureau has a reasonable basis to question the annual compensation payments reported by the self-insurer, it may require the self-insurer to retain the services of the self-insurer's licensed certified public accounting firm to audit the data reported to provided confirmation or make necessary adjustments.

§ 125.14. Change in legal status, ownership or financial condition

(a) A self-insurer shall submit promptly a renewal application to continue its self-insurance status under this subchapter in the event of a change in its or its parent's controlling interest, by sale or otherwise. Failure to comply with this subsection may result in the revocation of the self-insurer's permit.

(b) A self-insurer which amends its articles, charter or agreement of incorporation, association, partnership or sole proprietorship to change its identity or business structure shall promptly notify the Bureau in writing of that action. The Bureau may request copies of documents or information deemed necessary to determine whether the transaction has affected the ability of the employer to self-insure.

(c) A self-insurer shall promptly notify the Bureau in writing of any material adverse changes to its financial condition which occur after the date of the most recent financial statements submitted with its last application.

§ 125.15. Workers' compensation liability

(a) Notwithstanding the terms of a guarantee and assumption agreement executed under § 125.4(b) (relating to application for affiliates and subsidiaries), a self-insurer or a runoff self-insurer remains liable for workers' compensation on injuries or disease exposures occurring during its period of self-insurance. With application to and permission from the Bureau, liability can be transferred to another employer. Liability also may be transferred through a self-insurance loss portfolio transfer policy.

(b) A self-insurer which liquidates or dissolves shall transfer its liability to a third party, subject to the approval of the Bureau, or shall obtain a self-insurance loss portfolio transfer policy covering the liability.

(c) If a self-insurer sells or divests a part of itself, self-insurance coverage ends for the separated parts on the date of separation. The self-insurer remains liable for claims incurred against the separated part occurring up to the date of separation unless the Bureau approves a request to transfer the self-insurer's liability to another entity.

§ 125.16. Reporting by runoff self-insurer

(a) A runoff self-insurer shall file an annual report with the Bureau by a date prescribed by the Bureau on a prescribed form provided by the Bureau until all cases incurred during its period of self-insurance have been closed for at least 2 years.

(b) The runoff report must include a listing in a Bureau-prescribed electronic format provided by the Bureau to the runoff self-insurer of the runoff self-insurer's Pennsylvania workers' compensation claims, including all claims currently in litigation, and information such as payments and reserves on each claim. The listing must include:

(i) All open claims at the time of submission.

(ii) All claims closed on or after September 11, 2010.

(iii) Case reserves provided in the listing must be established according to the instructions on forms prescribed by the Bureau and provided to the runoff self-insurer.

(c) A runoff self-insurer that is a private employer shall make any request for the adjustment of its amount of security in writing when it submits its runoff report. If the runoff self-insurer disagrees with the Bureau's decision on the request, it may request reconsideration of this decision under § 125.6(e) (relating to decision on application).

§ 125.17. Claims service companies

(a) A claims service company desiring to engage in the business of adjusting and handling claims for an approved self-insurer shall register with the Bureau as provided under section 441(c) of the act (77 P. S. § 997(c)) and regulations thereunder on a prescribed form before entering into a contract to provide these services. The claims service company shall answer the questions on the registration form and swear to the information provided on the form.

(b) A claims service company shall have adequate facilities and employ competent staff to provide claims services in a manner which fulfills a self-insurer's obligations under the act, the Occupational Disease Act and this part. A claims service company which repeatedly or unreasonably fails to provide claims adjusting or services promptly with the result that compensation is not paid as required under the act or the Occupational Disease Act may have its privilege of conducting this business revoked or suspended under the procedures of section 441(c) of the act.

(c) The claims service company shall employ at least one person on a full-time basis who has the knowledge and experience necessary to service claims properly under the act and the Occupational Disease Act. A resume covering that person's background must be attached to the registration form of the claims service company.

(d) A claims service company whose engagement to handle or adjust the claims of a self-insurer is terminating or expiring, or has terminated or expired, shall provide reasonable assistance to the self-insurer and the Bureau in providing data and information on the claims serviced to maintain the integrity of past data on the claims filed with the Bureau, to rectify or explain discrepancies or questions on the claims data raised by the Bureau, or to address other related issues identified by the Bureau.

§ 125.18. Contact person

A self-insurer shall provide the Bureau with the name, title, address and phone number of a contact person who will be the liaison with the Bureau regarding all self-insurance matters, including the processing of applications, the provision of information and the payment of assessments, and to whom self-insurance correspondence will be sent. The self-insurer shall give written notice of a change in contact person or change in address or telephone number within 10 days of this change.

§ 125.19. Additional powers of Bureau and orders to show cause

(a) If the Bureau has reason to question whether a self-insurer continues to maintain the financial ability to self-insure during the pendency of a permit, authorized under section 305(a)(3) of the act (77 P. S. § 501(a)(3)) and under section 305 of the Occupational Disease Act (77 P. S. § 1405), it will issue a letter to the self-insurer noting the reasons for its concerns and outlining the documents, data and information upon which the Bureau's concerns are based. The following also apply:

(1) The Bureau's letter is treated for procedural purposes as if it were an initial decision denying a renewal application under § 125.6(d) (relating to decision on application).

(2) When the Bureau determines that the self-insurer no longer possesses the financial ability to self-insure, the self-insurer's current permit will be revoked, unless the self-insurer timely initiates the procedures outlined under § 125.6(e) — (g).

(3) The self-insurer shall obtain workers' compensation insurance coverage effective no later than 30 days after its receipt of a notice of revocation by the Bureau and provide evidence of the coverage, such as a certificate of insurance, to the Bureau no later than the coverage's effective date.

(b) The Department may serve upon a self-insurer an order to show cause why its self-insurance status should not be suspended or revoked under section 441(b) of the act (77 P. S. § 997(b)) for unreasonably failing to pay compensation for which it is liable, or for failing to submit any report or to pay any assessment made under the act.

(1) The order to show cause proceedings are governed by provisions in Chapter 121 (relating to general provisions), found in § 121.27 (relating to orders to show cause).

(2) The self-insurer shall obtain workers' compensation insurance coverage effective no later than 30 days after its receipt of an order revoking or suspending its self-insurance status and provide evidence of the coverage, such as a certificate of insurance, to the Department no later than the coverage's effective date.

§ 125.20. Computation of time

Except as otherwise provided by law, in computing a period of time prescribed or allowed by this chapter, the day of the act, event or default after which the designated period of time begins to run may not be included. The last day of the period so computed shall be included, unless it is Saturday, Sunday or a legal holiday in this Commonwealth, in which event the period shall run until the end of the next day which is neither a Saturday, Sunday nor a holiday. A part-day holiday shall be considered as other days and not as a holiday. Intermediate Saturdays, Sundays and holidays shall be included in the computation.

§ 125.21. Self-insurance loss portfolio transfer policy

A self-insurance loss portfolio transfer policy must comply with all of the following:

(1) The insurance carrier must be a workers' compensation insurer.

(2) The policy must provide statutory coverage limits and state that the insurer is responsible to defend, adjust and handle all open, reopened and incurred but not reported claims against the self-insurer for the period of time covered by the policy.

(3) The policy must be retrospective, providing coverage for a consecutive period of time of self-insurance.

(4) The policy must be noncancelable by either the insurance carrier or the self-insurer for any reason.

(5) The amount of annual compensation paid by the insurance carrier on any claims assumed under the policy must be included as compensation paid on the data reports filed with the Insurance Department.

(6) The insurance carrier must include the premium received on the policy in the amount of net written workers' compensation premium it annually reports to the Insurance Department or to the National Association of Insurance Commissioners.

(7) The insurance carrier must notify existing claimants with injuries or diseases covered by the policy that it has assumed liability for the payment and handling of their claims.

(8) The insurance carrier must file the policy with a rating organization approved by the Insurance Commissioner and identify it as a special self-insurance loss portfolio transfer policy. The insurance carrier should not report statistical information on claims assumed under the policy to the rating organization.

(9) The insurance carrier must enter an appearance with the appropriate workers' compensation judge, the Workers' Compensation Appeal Board and any appellate court on each pending claim in adjudication against the self-insurer for injuries or disease exposures occurring during the time period covered by the policy.

SUBCHAPTER B. GROUP SELF-INSURANCE

§ 125.101 – 125.123. [Reserved]

§ 125.131. Purpose

This subchapter is promulgated under sections 435 and 818 of the act (77 P. S. §§ 991 and 1036.18) to provide regulatory guidelines for uniform and orderly administration of group self-insurance funds under Article VIII of the act (77 P. S. §§ 1036.1 — 1036.18). This subchapter will ensure full payment of compensation due under the act and the Occupational Disease Act to employes of employers that pool their liabilities through participation in a group self-insurance fund.

§ 125.132. Definitions

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

Act — The Workers' Compensation Act (77 P. S. §§ 1 — 1038.2).

Administrator — An administrator as defined in section 801 of the act (77 P. S. § 1036.1).

Aggregate excess insurance — Insurance which provides that the excess insurer pays on behalf of or reimburses a fund for its payment of benefits on claims incurred during a policy period in excess of the retention amount to the excess insurer's limit of liability.

Applicant — A group of five or more homogeneous employers requesting approval of the Bureau to operate as a fund.

Board of trustees — The governing body of a fund.

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

Claims service company — An individual, corporation, partnership or association engaged in the business of servicing a fund's claims, including the adjusting and handling of claims, the payment of benefits and the provision of required reports.

Contributions — The amount of money charged each member to fund the obligations and expenses of a fund. The term includes charges calculated and made known to the members prior to the beginning of each fund year, and adjustments to those charges made during the fund year by the board of trustees.

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

Dividends — Cash, contribution credits or similar distributions provided to the members from surplus.

Employer — An employer as defined in section 801 of the act.

Excess insurer — An insurance company authorized to transact the class of insurance listed in section 202(c)(14) of The Insurance Company Law of 1921 (40 P. S. § 382(c)(14)).

Fiscal agent — An individual, corporation, partnership or association engaged by a fund to carry out the fiscal policies of the fund and to invest, manage, hold and disburse fund assets. The board of trustees may delegate the duties of fiscal agent to the administrator.

Fund — A fund as defined in section 801 of the act. The fund shall assume the liabilities and obligations of its members under the act and the Occupational Disease Act.

Fund year — The fiscal year and annual reporting period of a fund, which shall consist of 12 calendar months, except for the first year, which may consist of fewer or more than 12 months as established by the Bureau.

Homogeneity — Homogeneity exists where a fund is comprised of homogeneous employers.

Homogeneous employers — Employers who have been assigned to the same classification series for at least 1 year or are engaged in the same or similar types of business, including political subdivisions.

Independent actuary — An independent actuary as defined in section 801 of the act.

Loss costs — The dollar amounts per unit of exposure attributable to the payment of losses under the act and the Occupational Disease Act, filed by a rating organization based on aggregate experience of all members of that rating organization and approved by the Insurance Commissioner under Article VII of the act (77 P. S. §§ 1035.1 — 1035.22).

Loss-cost multiplier — A factor approved by the Bureau for each fund which is multiplied against the loss costs to recoup the fund's administrative and operating costs and expenses, including:

(i) The fund's costs in connection with the examination, investigation, handling, adjusting and litigation of claims.

(ii) The cost of excess insurance, loss control services, underwriting services, assessments and taxes.

(iii) The fees and commissions for accountants, attorneys, actuaries, investment advisors and other specialists whose services are necessary for the operation and administration of the fund.

Member — An employer participating in a fund.

Occupational Disease Act — The Pennsylvania Occupational Disease Act (77 P. S. §§ 1201 — 1603).

Permit — A permit as defined in section 801 of the act.

Plan committee — A plan committee as defined in section 801 of the act.

Political subdivision — A political subdivision as defined in section 801 of the act.

Retention amount — The maximum amount of benefits a fund would be required to pay without reimbursement from the excess insurer under an aggregate or specific excess insurance policy.

Runoff fund — A fund which voluntarily terminated its permit or a fund whose permit was revoked by the Bureau.

Security — Security as defined in section 801 of the act.

Service company — A claims service company and all other individuals, corporations, partnerships or associations engaged by a fund to provide the fund with services such as legal assistance, underwriting,

safety engineering, loss control, medical management, information analysis, statistics compilation, loss and expense report preparation and contribution development.

Specific excess insurance — Insurance which provides that the excess insurer pays on behalf of or reimburses a fund for its payment of benefits on each occurrence in excess of the retention amount to the excess insurer's limit of liability.

Surplus — Surplus as defined in section 801 of the act. In determining surplus, incurred but not reported claims shall be included in the calculation of incurred losses.

Trust agreement — A trust as defined in section 801 of the act.

Trustee — Each person serving as a member of the board of trustees.

§ 125.133. Application

(a) An applicant shall file an application on a form prescribed by the Bureau. 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. The application shall be signed by a representative of the applicant and attested to as set forth on the application. Any attached rider and applicable form enclosed with the application shall be verified to in the sworn affidavit requested on the application.

(b) Applications shall be filed with the Bureau no later than 90 days prior to the requested effective date of the fund.

(c) With the application, the applicant shall include:

(1) The nonrefundable fee in the amount of $1,000 required by section 802(c) of the act (77 P. S. § 1036.2(c)).

(2) The audited financial statements presented in conformity with generally accepted accounting principles of one prospective member with a net worth of at least $1 million or of more than one prospective member with aggregate net worth of at least $1 million, or an amount as may be promulgated annually by the Bureau and published in the Pennsylvania Bulletin to take effect on January 1 of each year. This paragraph does not apply to applicants composed of political subdivisions.

(3) The prior fiscal year's audited or reviewed financial statements of each prospective member whose annual contribution to the fund would make up more than 10% of the total annual contributions to the fund.

(4) An explanation of the same classification series, as described under § 125.155(a) (relating to homogeneity), common to all prospective members with the amount of each member's contributions derived from the classification codes within the common series, or an explanation of how the prospective members are engaged in the same or similar types of business, as described under § 125.155(b). The Bureau may request additional information to determine the homogeneity of the applicant.

(5) If the applicant is eligible under § 125.135 (relating to classification system; experience rating; contributions rates) and is requesting to deviate from the loss costs of a rating organization as defined under section 703 of the act (77 P. S. § 1035.3), a report prepared by an independent actuary projecting the workers' compensation incurred loss experience of the applicant during

its first fund year by various levels of actuarial confidence and rendering an opinion that the rates requested for use will be adequate to satisfy the applicant's obligations and expenses.

(6) A schedule of the projected annual contributions which will be paid by each prospective member and in total during the first fund year and worksheets showing the calculation of each prospective member's annual contributions.

(7) A schedule of projected administrative expenses in dollar amounts and as a percentage of the estimated total member contributions for the first fund year.

(8) The applicant's proposed trust agreement and bylaws, which shall include:

(i) A pledge that each member will be jointly and severally liable for the expenses and other obligations of the fund and for each other member's workers' compensation liability which is incurred while it is a member, including liability for assessments on claims incurred during a member's membership but not issued until after it has terminated membership.

(ii) A pledge that the applicant will remain liable to pay and administer the claims incurred by members while they participated in the fund.

(iii) The powers, duties and responsibilities of the board of trustees.

(iv) The structure of the board of trustees.

(v) The method of appointing, removing and replacing trustees by the plan committee.

(vi) The persons or committee responsible for the acquisitions, management, investment and disposition of real and personal property of the fund.

(vii) The rights, privileges and obligations of the members.

(viii) Procedures for amending the trust agreement and the bylaws, which shall require the approval of the plan committee.

(ix) Requirements for membership.

(x) Procedures for the withdrawal or expulsion of members.

(xi) Rules on payment and collection of contributions and assessments.

(xii) Procedures for resolving disputes between members and the fund.

(xiii) The powers and responsibilities of the plan committee.

(xiv) Procedures for calling special meetings of the board of trustees and the plan committee.

(xv) Delineation of authority granted to the administrator, the fiscal agent and the service companies.

(9) Policy statements on the following subjects:

(i) Underwriting standards.

(ii) Asset investment policies and strategy based on permitted investments of capital or surplus of stock casualty insurance companies in section 602 or 603 of The Insurance Company Law of 1921 (40 P. S. §§ 722 and 723) (Repealed). For the purpose of this subparagraph, permitted investments of capital or surplus of stock casualty insurance companies in section 602 or 603 of The Insurance Company Law of 1921 shall include investments permitted for domestic stock casualty insurance companies under section 602.1 of The Insurance Company Law of 1921 (40 P. S. § 722.1).

(iii) The timing, frequency and calculation of supplemental assessments needed to maintain actuarially appropriate reserves.

(iv) The payment of dividends and the maintenance of surplus.

(v) Procedures and policies on member payroll audits and the adjustment of contributions based on the results of the audits.

(10) Membership applications executed by each prospective member and approved by the applicant on a form prescribed by the Bureau. The membership application will also serve the purpose of the letter of intent required under section 802(b)(12) of the act.

(11) A report on a form prescribed by the Bureau summarizing the scope, function and operation of the proposed loss prevention and safety program required under sections 802(b)(13) and 1001(b) of the act (77 P. S. §§ 1036.2(b)(13) and 1038.1(b)) and regulations thereunder.

(12) The applicant's proposed loss-cost multiplier on a form prescribed by the Bureau.

(d) The Bureau will not begin its review of the application until the application and the required supporting materials as outlined in this section have been submitted.

(e) The applicant shall provide additional data and information that the Bureau deems pertinent to its review of the application based on the factors enumerated under § 125.134 (relating to decision on application). The applicant shall provide data and information within the time prescribed by the Bureau, which will be reasonable based on the extent and the availability of the data and information required.

§ 125.134. Decision on application

(a) The application of an applicant which meets the requirements of the act relating to matters such as the number of homogeneous employers, aggregate net worth and aggregate premium will be approved if the Bureau determines that the applicant has demonstrated, with reasonable certainty, that it will meet the liabilities incurred by its members under the act and the Occupational Disease Act. The Bureau will include the following factors in assessing the applicant's ability to meet those liabilities:

(1) The adequacy of member contributions.

(2) The applicant's plans for the establishment of surpluses to absorb matters such as unexpected losses and uncollected contributions.

(3) The applicant's plans for member assessments needed to maintain actuarially appropriate loss reserves.

(4) Restrictions on the payment of dividends on surplus.

(5) The overall financial ability of the members to satisfy their obligations to the applicant.

(6) The applicant's ability to control losses through the safety and loss control program proposed.

(7) The excess insurance coverage obtained by the fund, if any.

(8) The validity of the actuarial assumptions used to predict the likely loss levels, if any.

(9) The liquidity and safety of the fund's assets.

(10) The likely stability of membership in the fund.

(11) The adequacy of the trust agreement, bylaws and written policies.

(12) The degree to which the total risk of the fund is spread among the members.

(b) If the Bureau's assessment under subsection (a) is that the applicant can meet its obligations, it will send to the applicant a preliminary approval notice of the application and a list of conditions under subsection (d) that shall be met before the applicant may operate as a fund.

(c) An applicant has 60 days from the receipt of the preliminary approval notice to comply with the conditions set forth by the Bureau. The applicant may toll the 60-day compliance period by filing a request for a conference under subsection (f). An applicant may be granted a 30-day extension to meet the conditions if the applicant requests an extension in writing to the Bureau within the initial 60-day compliance period. The application of an applicant which does not meet the conditions within the compliance period will be deemed withdrawn.

(d) The applicant will be issued a permit which is effective no sooner than 15 days after the following has been filed with the Bureau:

(1) The trust agreement and bylaws as approved by the Bureau and executed by the members.

(2) Security in an amount as determined by the Bureau, if any. This requirement does not apply to funds comprised exclusively of political subdivisions.

(3) A certificate providing evidence of excess insurance as required by the Bureau.

(4) Confirmation of the name and address of the administrator, fiscal agent and of service companies the applicant will use.

(5) Certification by the administrator that each member has paid 25% of its annual contribution to the fund.

(6) One or more fidelity bonds to protect the fund against misappropriation or misuse of assets on a form and in an amount approved by the Bureau. The fidelity bonds shall cover the individuals and contractors who will handle fund assets or who will have authority to gain access to fund assets, including trustees, the administrator, the fiscal agent and the claims service company. The fiscal agent need not be covered by a bond if it is a duly chartered commercial bank or trust company.

(7) Documents relating to other requirements set by the Bureau to protect the compensation rights of employes of members.

(e) If upon review of the pertinent data the Bureau finds that the applicant does not meet the requirements of subsection (a), it will send to the applicant a written preliminary denial notice of the application. The notice will state the documents, evidence and other data received from the applicant or otherwise reviewed or considered by the Bureau in reaching its preliminary determination.

(f) The applicant may request a conference with the Bureau upon receipt of the Bureau's preliminary approval notice or denial notice. A conference request shall be made in writing within 20 days after the receipt of the preliminary notice. At the conference, the applicant may present additional evidence or data to support its application or the alteration of the conditions required in the preliminary approval notice. The applicant may present that information to the Bureau in writing, or in person, or both.

(g) After a conference and the receipt of written submissions, the Chief of the Self-Insurance Division of the Bureau will promptly review the entire record of the applicant and will issue a reconsideration decision on the application.

(h) An applicant shall have a right to appeal a reconsideration decision issued under subsection (g) with the Bureau within 30 days of the receipt of the reconsideration decision. Untimely appeals will be dismissed without further action by the Bureau. A hearing will be conducted on the appeal as specified in § 125.154 (relating to hearings).

§ 125.135. Classification system; experience rating; contribution rates

(a) A fund shall adhere to the uniform classification system and uniform experience rating plan filed with the Commissioner of the Insurance Department by a rating organization under Article VII of the act (77 P. S. §§ 1035.1 — 1035.22).

(b) A fund shall base its member contribution rates on no less than the current effective loss costs plus the fund's approved loss-cost multiplier. A fund may also reduce a member's contribution rates for up to 5 years by 5% if the member establishes a workplace safety committee which received certification by the Department and continues to meet certification requirements under section 1002 of the act (77 P. S. § 1038.2) and regulations thereunder.

(c) No later than 45 days prior to the beginning of a fund year, a fund may request the Bureau's permission to change its loss-cost multiplier for member contributions payable during that next fund year. The request to change a fund's loss-cost multiplier shall be on a form prescribed by the Bureau. The fund may support its loss-cost multiplier request with a report prepared by an independent actuary but an actuarial report is not required.

(d) If the Bureau determines that the loss-cost multiplier requested under subsection (c) is unreasonably low, so that it impairs the fund's ability to meet its expenses, the Bureau will notify the fund that the loss-cost multiplier request is denied. The notification will be sent to the fund no later than 30 days after the filing of the request. Use of a loss-cost multiplier which has not been approved by the Bureau shall result in the revocation of the fund's permit under section 805(a) of the act (77 P. S. § 1036.5).

(e) No later than 45 days prior to the beginning of a fund year following its third year of operation, a fund may request permission of the Bureau to deviate from the uniform classification system, uniform experience rating plan, loss costs and discounts outlined in subsections (a) and (b), including the use of retrospectively rated and deductible plans. An applicant comprised of a majority of prospective members who are participants in a group insurance purchase cooperative/safety group for at least 3 years prior to the submission of its application or comprised of a majority of prospective members who are political subdivisions approved as self-insurers under

section 305 of the act (77 P. S. § 501) may also request permission of the Bureau to deviate from the requirements of subsections (a) and (b).

(f) A deviation request under subsection (e) shall be supported by a report prepared by an independent actuary projecting the incurred loss experience of the fund for its next fund year by various levels of actuarial confidence and rendering an opinion that the total contributions received if the deviation is permitted will be adequate to satisfy the applicant's obligations and expenses. A request for deviation from the loss costs of a rating organization shall include a schedule of the loss costs proposed for the fund year.

(g) If the Bureau determines that the deviation requested under subsection (e) may impair the fund's ability to meet its obligations, it will notify the fund that the deviation request is denied. The notification will be sent to the fund no later than 30 days after the filing of the request. Use of loss costs which have not been approved by the Bureau will result in the revocation of the fund's permit under section 805(a) of the act (77 P. S. § 1036.5).

§ 125.136. Addition of members

(a) The addition of a new member to a fund shall be approved on an application form prescribed by the Bureau. The approval shall be granted by the plan committee or the board of trustees or by the administrator if the board of trustees has delegated this authority to the administrator.

(b) The approved application form for fund membership shall be filed with the Bureau no more than 15 days after the effective date of the employer's membership in the fund.

(c) With the approved application, the fund shall submit to the Bureau:

(1) Evidence of the prospective member's execution of the trust agreement and the bylaws.

(2) A schedule of the prospective member's annual contributions to the fund.

(3) The prospective member's prior year's audited or reviewed financial statement if its annual contributions will make up more than 10% of total annual contributions to the fund.

(d) The fund shall provide to the Bureau financial information requested by the Bureau to determine whether the addition of a member will affect the fund's continuing ability to satisfy its obligations, such as special financial statements or projections.

(e) The Bureau will notify the fund and the new member if it finds that the new member will disturb the homogeneity of the fund. The new member's participation in the fund shall terminate 15 days after the issuance of the notice.

§ 125.137. Withdrawal or expulsion of members

(a) A fund shall notify the Bureau in writing of the withdrawal or expulsion of a member no less than 15 days prior to the effective date of the withdrawal or expulsion.

(b) Each member which withdraws or is expelled from a fund shall provide to the Bureau a certificate providing evidence of its workers' compensation coverage by the effective date of its withdrawal or expulsion.

(c) The fund shall provide to the Bureau any financial information requested by the Bureau to determine whether the withdrawal or expulsion of a member will affect the fund's continuing ability to satisfy its obligations, such as special financial statements or projections.

§ 125.138. Change in legal status, ownership, financial condition, name and address of member

(a) A member shall promptly notify the fund in writing in the event of a change in its or its parent's controlling interest, by sale or otherwise.

(b) A member which amends its articles, charter or agreement of incorporation, association, partnership or sole proprietorship to change its identity or business structure shall promptly notify the fund in writing of that action.

(c) A member shall promptly notify the fund in writing of any material adverse changes to its financial condition.

(d) A member shall promptly notify the fund in writing of any changes in its name or address.

(e) The fund shall promptly notify the Bureau in writing of changes reported by members under subsections (a) — (d).

§ 125.139. Change of administrator, fiscal agent or service companies

A fund shall promptly notify the Bureau in writing of a change in its administrator, fiscal agent or its service companies.

§ 125.140. Change of trust agreement, bylaws or written policies; notification of insufficient assets

(a) A fund shall promptly file with the Bureau amendments to its trust agreement or bylaws or amendments to its written policies which could materially affect the operation of the fund.

(b) A fund which knows, or should know, that it has insufficient assets to maintain actuarially appropriate loss reserves as defined under section 801 of the act (77 P. S. § 1036.1) shall immediately notify the Bureau in writing of this condition. With the notification, the fund shall inform the Bureau of its plan to correct the deficiency.

§ 125.141. Annual report

(a) No more than 5 months following the end of each fund year, a fund shall file a report with the Bureau as required by section 815 of the act (77 P. S. § 1036.15). Failure to file an annual report in the time prescribed may result in the revocation of the fund's permit.

(b) The fund shall submit with its annual report:

(1) The evaluation fee in the amount of $1,000 required by section 815(c) of the act.

(2) The fund's audited financial statements for its prior fund year as prepared by a certified public accountant in accordance with generally accepted accounting principles.

(3) A report prepared by an independent actuary projecting the value of the fund's incurred and outstanding liability by fund year.

(4) The prior fiscal year's audited or reviewed financial statements of each member whose annual contribution to the fund makes up more than 10% of the total annual contributions to the fund.

(5) A schedule of the projected administrative expenses in dollar amounts and as a percentage of the total member contributions for the current fund year.

(6) A schedule of the annual contributions which will be paid by each member and in total during the current fund year and worksheets showing the calculation of each member's annual contributions.

(7) A certificate providing evidence of excess insurance as required by the Bureau.

(8) A schedule of member dividends paid during the prior fund year and the fund year from which the dividends were paid.

(9) A schedule of the dividends the fund plans to return to its members during the current year. The schedule shall include a recommendation from an independent actuary that the dividends proposed will not impair the fund's ability to meet its obligations and that the dividends will comply with the other requirements of section 809 of the act (77 P. S. § 1036.9).

(10) Confirmation of the existence of the fidelity bonds required under § 125.134(d)(6) (relating to decision on application).

(c) A fund shall provide to the Bureau other information required by the Bureau to determine whether the fund has the ability to continue to satisfy its obligations and expenses.

(d) The Bureau may require a fund to file interim reports during its fund year of its financial condition, claims experience and other items the Bureau may require.

(e) Extensions of the filing date under subsection (a) may be granted by the Bureau for 30-day periods upon good cause shown by the fund in stating its reasons for requesting the extension. The request for extension shall be submitted in writing no less than 10 days prior to the due date in sufficient detail to permit the Bureau to make an informed decision with respect to the requested extension.

§ 125.142. Maintenance of fund permit

Following the submission of a fund's annual report or at other times determined by the Bureau, the Bureau may revise the conditions previously set for the issuance of the fund's permit. The fund's permit may be revoked if the revised conditions are not met in the time prescribed by the Bureau, subject to the right of a hearing under § 125.154 (relating to hearings).

§ 125.143. Restriction on the use of assets

(a) A fund, its board of trustees, fiscal agent or administrator may not use member contributions for a purpose unrelated to the satisfaction of the workers' compensation obligation of the fund and expenses related to those obligations.

(b) The board of trustees, administrator or fiscal agent of the fund may not borrow money from the fund or in the name of the fund, including the issuance of loan guarantees or other forms of encumbrances.

(c) A fund may not extend credit to a member for payment of contributions. This subsection does not prohibit the payment of annual contributions based on an installment plan as presented in the schedule submitted to the Bureau in § 125.133(c)(6) or § 125.141(b)(6) (relating to application; and annual report).

§ 125.144. Revocation and voluntary termination of permit

(a) Upon the revocation or voluntary termination of a permit under sections 805(a) or 808(c) of the act (77 P. S. §§ 1036.5 and 1036.8), members shall insure their liabilities to pay compensation as required by the act.

(b) Upon the approval of the Bureau, a revoked or terminated fund may be allowed to operate as a runoff fund to pay claims incurred during the effective period of its permit from assets currently on hand or from assessments of its members. Absent this approval, a revoked or terminated fund shall make its best efforts to insure the workers' compensation liability incurred prior to the revocation or termination of its permit with a carrier licensed to write workers' compensation in this Commonwealth. The revoked or terminated fund shall pay insurance premiums from its assets and from assessments of its members, if necessary.

(c) Upon proof provided to the Bureau that a revoked or terminated fund is unable to obtain insurance coverage for the workers' compensation liability incurred prior to the revocation or termination of its permit, the revoked or terminated fund shall operate as a runoff fund and shall pay claims on the liability from its assets and from assessments of its members.

§ 125.145. Merger of funds

(a) Subject to the prior written approval of the Bureau, a fund may merge with another fund with the same homogeneous characteristics if the resulting fund assumes in full all obligations of the merging funds.

(b) The resulting fund may be a continuing fund under the name of one or more of the merged funds or a new fund whose name shall be subject to the Bureau's approval. In all respects, the continuing fund or the new fund shall be subject to this subchapter. Funds merging under this section shall enter into a written agreement for the merger prescribing the merger's terms and conditions. The agreement shall be the following:

(1) Assented to by a majority of the plan committee and the board of trustees of each fund.

(2) Executed in duplicate by a majority of the board of trustees of each fund.

(3) Accompanied by copies of the resolutions authorizing the merger and the execution of the agreement attested by the recording officer of each fund.

(4) Submitted to the Bureau, with the records of the fund pertaining thereto.

(c) If the requirements of subsections (a) and (b) have been complied with, the Bureau will issue a new permit to the merged fund with the powers retained and specified in the agreement.

(d) Upon merger, the rights and properties of the several funds shall accrue to and become the property of the merged fund, which shall succeed to all the obligations and liabilities of the merged funds, in the same manner as if they had been incurred or contracted by it. The members of the merged fund shall continue to be subject to all the liabilities, claims and demands existing against them at or before the merger.

(e) No action or proceeding pending at the time of the merger in which any or all of the funds merged may be a party will abate or be discontinued by reason of the merger, but the same may be prosecuted to final judgment in the same manner as if the merger had not taken place, or the continuing fund or the new fund may be substituted in place of a fund so merged by order of the court in which the action or proceeding may be pending.

(f) Members of either merging fund who do not wish to belong to the merged fund may withdraw their membership at the time of the merger without penalty. They will remain jointly and severally liable for the claims, expenses and other obligations incurred by the fund during the period of their membership and prior to the merger.

§ 125.146. Payment of dividends

(a) Payment of dividends to members as permitted in section 809 of the act (77 P. S. § 1036.9) may not be made sooner than 60 days following a fund's filing of its annual report as required by § 125.141 (relating to annual report). A runoff fund may not pay dividends sooner than 60 days following its filing of the report required by § 125.150 (relating to runoff fund).

(b) If the Bureau determines that the payment of proposed dividends may impair the fund's ability to meet its obligations or may violate other provisions of section 809 of the act, it will notify the fund that the dividend payment is prohibited. The notification will be sent to the fund no later than 45 days after the filing of the annual report. Payment of dividends which have not been approved by the Bureau will result in the revocation of the fund's permit under section 805(a) of the act (77 P. S. § 1036.5(a)).

§ 125.147. Special funds assessments

(a) A fund is responsible for the payment of assessments to maintain funds under the act, including:

(1) The Workmen's Compensation Administration Fund.

(2) The Subsequent Injury Fund.

(3) The Workmen's Compensation Supersedeas Fund.

(4) The Self-Insurance Guaranty Fund.

(b) A runoff fund is liable for the payment of any assessments made after the termination or revocation of its permit until it has discharged the obligations to pay compensation which arose during the effective period of its permit. The assessments of a runoff fund shall be based on the payment of claims that arose during the effective period of the fund's permit.

(c) A fund shall keep accurate records of compensation paid on a calendar year basis, including payment for disability of all types, death benefits, medical benefits and funeral expenses, for the purposes of assessments under the act. The records shall be available for audit or physical inspection by Bureau employes or other designated persons, whether in the possession of the fund or a service company.

§ 125.148. Security

The security required in § 125.134(d)(2) (relating to decision on application) shall be in one of the following forms:

(1) A surety bond on a form prescribed by the Bureau issued by a company authorized to transact surety business in this Commonwealth by the Insurance Department.

(i) The surety company shall possess a current A.M. Best Rating of B+ or better or a Standard and Poor's rating of claims paying ability of A or better.

(ii) The fund shall replace the bond with a new bond issued by a surety company with an acceptable rating or with another acceptable form of security if the surety company's rating falls below the acceptable rating after the bond is issued. If the bond is not replaced within 60 days, the Bureau will have discretion to draw on the surety bond and deposit the proceeds with the State Treasurer to secure the fund's obligation.

(2) A security deposit held under a trust agreement prescribed by the Bureau.

(i) The deposit shall consist of cash; bonds or other evidence of indebtedness issued, assumed or guaranteed by the United States, or by an agency or instrumentality of the United States; investments in common funds or regulated investment companies which invest primarily in United States Government or Government agency obligations; or bonds or other security issued by the Commonwealth and backed by the Commonwealth's full faith and credit.

(ii) The securities shall be held in a Commonwealth chartered bank and trust company or trust company as defined in section 102 of the Banking Code of 1965 (7 P. S. § 102) or a Federally chartered bank or foreign bank with a branch office and trust powers in this Commonwealth.

(3) An irrevocable letter of credit using language required by the Bureau issued by and payable at a branch office of a commercial bank located in the continental United States, Alaska or Hawaii. The letter of credit shall state that the terms of the letter of credit automatically renew annually unless the letter of credit is specifically nonrenewed by the issuing bank 60 days or more prior to the anniversary date of its issuance.

(i) At the time of issuance of the letter of credit, the issuing bank or its holding company shall have a B/C or better rating or 2.5 or better score by Thomson BankWatch or the issuing bank shall have a CD rating of BBB or better by Standard & Poor's Corporation.

(ii) The fund shall replace the letter of credit with a new letter of credit issued by a bank with an acceptable credit rating, or with another acceptable form of security, if the bank's rating falls below the acceptable rating after the letter of credit is issued. If the letter of credit is not replaced within 60 days, the Bureau will draw on the letter of credit and will deposit the proceeds to secure the fund's obligations.

(iii) The fund shall execute a standby trust agreement on a form prescribed by the Bureau with a Commonwealth chartered bank and trust company or trust company as defined in section 102 of the Banking Code of 1965 or a Federally chartered bank or foreign bank with a branch office and trust powers in this Commonwealth. The trust agreement will accommodate proceeds from a letter of credit drawn on by the Bureau.

§ 125.149. Specific excess insurance and aggregate excess insurance

(a) A fund shall obtain specific excess insurance with a retention amount and liability limit acceptable to the Bureau. The Bureau may waive this requirement upon written request if the fund demonstrates that it has sufficient financial strength and liquidity to assure that all obligations under the act and the Occupational Disease Act will be promptly met without the protection of an excess insurance policy.

(b) Aggregate excess insurance may be obtained by a fund. The Bureau will not recognize a contract or policy of aggregate excess insurance in considering the ability of a fund to fulfill its financial obligations unless the contract or policy complies with subsection (c).

(c) The contract or policy of aggregate excess insurance or specific excess insurance, or both, shall comply with the following:

(1) It shall be issued by an excess insurer which possesses an A. M. Best Rating of B+ or better or a Standard and Poor's rating of claims paying ability of A or better.

(2) It shall state that it is not cancelable or nonrenewable unless written notice by registered or certified mail is given to the other party to the policy and to the Bureau at least 45 days before termination by the party desiring to cancel or not renew the policy.

(3) It shall state that if the fund is unable to make benefit payments under the act and the Occupational Disease Act due to insolvency or bankruptcy, the excess carrier shall make the payments to other parties involved in the paying of the fund's obligations, as directed by the Bureau, subject to the policy's retentions and limits.

(4) It shall state that the following apply toward reaching the retention amount in the excess contract:

(i) Payments made by the fund.

(ii) Payments made on behalf of the fund under a surety bond or other forms of security as required under this subchapter.

(iii) Payments made by the Self-Insurance Guaranty Fund.

(5) It shall state that it applies to any losses of a fund under the act and the Occupational Disease Act; it may not exclude coverage for any categories of injuries or diseases compensable under the act or the Occupational Disease Act.

(d) A certificate of the excess insurance obtained by the fund shall be filed with the Bureau together with a certification that the policy fully complies with subsection (c).

§ 125.150. Runoff fund

(a) A runoff fund shall pay any obligations, prepare reports and administer transactions associated with the period when it was an approved fund. A runoff fund shall continue to comply with appropriate provisions of this subchapter as determined by the Bureau.

(b) A runoff fund shall file an annual report with the Bureau by a date prescribed by the Bureau on a prescribed form. This report shall be filed until all cases incurred by the runoff fund when it was a permittee are closed. The report shall include the information outlined in section 815(b) of the act (77 P. S. § 1036.15(b)).

§ 125.151. Claims service companies

(a) A claims service company desiring to engage in the business of handling and adjusting claims for a fund shall register with the Bureau as provided under section 441(c) of the act (77 P. S. § 997(c)), and regulations thereunder, on a prescribed form before entering into any contract to provide these services. The service company shall answer the questions on the registration form and shall swear to the information provided on the form.

(b) A claims service company shall have adequate facilities and employ competent staff to provide claims services in a manner which fulfills a fund's obligations under the act, the Occupational

Disease Act and this part. A claims service company which reportedly or unreasonably fails to provide claims adjusting or services promptly with the results that compensation is not paid as required under the act or the Occupational Disease Act may have the privilege of conducting the business revoked or suspended under section 441(c) of the act.

(c) The claims service company shall employ at least one person on a full-time basis who has the knowledge and experience necessary to service claims under the act and the Occupational Disease Act. A resume covering that person's background shall be attached to the registration form of the claims service company.

§ 125.152. Board of trustees

(a) The board of trustees of a fund shall establish the fund's policies, ensure its fiscal stability and engage and delegate functions to its administrator, fiscal agent and service companies on behalf of the plan committee.

(b) Trustees shall be appointed by a fund's plan committee in accordance with the trust agreement and the bylaws.

(c) At least 2/3 of a fund's trustees shall be members of its plan committee. A member may not be represented by more than one trustee on the board of trustees. A fund's administrator, service companies or an officer, owner, employe of or another person or corporation affiliated with the administrator or service companies may not serve as a voting trustee, unless the administrator or service company is an organization consisting of political subdivisions, the income of which is not subject to Federal income taxation. An administrator or service company may serve as a nonvoting trustee.

(d) Each trustee shall act as a fiduciary for the benefit of employees of members and shall carry out his powers and responsibilities under the trust agreement independent of any powers and responsibilities he may possess or exercise as an employee, officer or director of a member.

(e) If an association of employers assist in the establishment of more than one fund, the plan committees of the several funds may decide to participate in a single board of trustees to oversee the operations of the several funds. The following restrictions and requirements apply to that single board of trustees:

(1) Each of the several funds shall be equally represented on the board of trustees.

(2) The pledge of joint and several liability of a member of a fund applies only to the liabilities and obligations of that member's fund; it does not apply to the other funds participating in the single board of trustees.

(3) Only the trustee-representatives of a specific fund shall vote on matters relating to the amendment of that fund's trust agreement or bylaws.

(4) Only the trustee-representatives of a specific fund shall set policies and make determinations governing the admission of members and the requirements for membership in that fund.

(5) At least 2/3 of the single board of trustees shall be members of the plan committees of the several funds. Other restrictions on the makeup of the board outlined under subsection (c) also apply to the single board of trustees.

§ 125.153. Additional powers of Bureau

In addition to the powers enumerated elsewhere in this subchapter and the act, the Bureau will have the authority, after notice and opportunity for hearing, to suspend a fund's operation, to issue cease and desist orders and to order corrective actions if a fund, its administrator or service companies are in violation of this subchapter or the act.

§ 125.154. Hearings

(a) The Director of the Bureau will assign appeals to decisions or orders issued under this subchapter and Article VIII of the act (77 P. S. §§ 1036.1 — 1036.18) to a hearing officer who will schedule a de novo hearing on the appeal from the initial decision or order. The applicant or the fund will receive reasonable notice of the hearing date, time and place.

(b) The hearing will be conducted in a manner to provide the applicant or the fund and the Bureau the opportunity to be heard. The hearing officer will not be bound by strict rules of evidence. 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 applicant or the fund will be provided the opportunity to submit briefs addressing issues raised.

(d) Following the close of the record, the hearing officer will promptly issue a written decision and order. The decision and order will include relevant findings and conclusions, and state the rationale of the decision. The decision will be served upon the applicant or the fund, the Bureau and counsel of record.

(e) An applicant, fund or the Bureau, aggrieved by a decision rendered under subsection (d), may appeal the decision to Commonwealth Court.

§ 125.155. Homogeneity

(a) The definition of "homogeneous employer" under section 801 of the act (77 P. S. § 1036.1) and under § 125.132 (relating to definitions) is deemed satisfied as to employers who have been assigned to the same classification series if the members derive a majority of their contributions from codes within the same classification group listed in a manual of risk classes approved by the Commissioner of the Insurance Department under Article VII of the act (77 P. S. §§ 1035.1 — 1035.22).

(b) The definition of "homogeneous employer" under section 801 of the act and under § 125.132 is deemed satisfied as to employers engaged in the same or similar types of business if the members have been assigned to the same two-digit major group of the four-digit Standard Industrial Classification system published by the Federal Office of Management and Budget or if the members have been assigned to three-digit industry groups outside of the primary two-digit major group which the Bureau has determined share substantial common aspects of production or services with the industries within the primary two-digit major group.

(c) Prospective members affiliated through common ownership or control shall be considered one employer for the purpose of calculating the number of homogeneous employers participating in a fund.

(d) Political subdivisions are homogeneous employers. Political subdivisions may not participate in funds which include employers who are not political subdivisions.

§ 125.156. Computation of time

Unless otherwise provided, reference to "days" in this subchapter shall 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, legal holiday or a day on which the Bureau's offices are closed, the time for filing shall be extended to the next business day. Transmittal by mail shall mean by first-class mail.

SUBCHAPTER C. SELF-INSURING GUARANTY FUND

§ 125.201. Purpose

This subchapter is promulgated under sections 435 and 908 of the act (77 P. S. §§ 991 and 1037.8) to provide regulatory guidelines for uniform and orderly administration of the guaranty fund.

§ 125.202. Definitions

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

Act — The Workers' Compensation Act (77 P. S. §§ 1 — 1038.2).

Basis of premium — The basis for the computation of an employer's workers' compensation insurance premium, such as employe remuneration paid by the employer.

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

Compensation — Compensation as defined in section 901 of the act (77 P. S. § 1037.1).

Custodial accounts — The two distinct and separate accounts of the guaranty fund established under section 902(c) of the act (77 P. S. § 1037.2(c)). One account is to be used exclusively to pay benefits arising from defaulting individual self-insurers and one account is to be used exclusively to pay benefits arising from defaulting group self-insurance funds.

Default — The failure of a self-insurer to pay compensation due to the self-insurer's financial inability or the self-insurer filing for bankruptcy or being declared bankrupt or insolvent.

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

Employer — An employer as defined in section 901 of the act.

Guaranty fund — The guaranty fund as defined in section 901 of the act.

Manual premium — The sum of an employer's basis of premium for each classification for the 12-month period immediately prior to the effective date of its individual self-insurance status under section 305 of the act (77 P. S. § 501) or of its membership in a group self-insurance fund under Article VIII of the act (77 P. S. §§ 1036.1 — 1036.18) multiplied by the applicable SWIF rate in effect at the time of the issuance of the insurance policy immediately prior to the employer's individual self-insurance status or its membership in a group self-insurance fund.

Modified manual premium — An employer's manual premium multiplied by its experience modification factor for the insurance policy immediately prior to the employer's individual self-insurance status or its membership in a group self-insurance fund, before adjustments or discounts.

New individual self-insurer — An employer operating as a self-insurer under its first permit, including an employer operating as a self-insurer under its first permit following the lapse of a previous period of self-insurance.

New group self-insurance fund — A group self-insurance fund initiating operation under the act.

Occupational Disease Act — The Pennsylvania Occupational Disease Act (77 P. S. §§ 1201 — 1603).

Runoff group self-insurance fund — A group self-insurance fund which voluntarily terminated the permit issued to it under Article VIII of the act or a group self-insurance fund whose permit was revoked by the Bureau.

Runoff individual self-insurer — An employer that had been a self-insurer under section 305 of the act (77 P. S. § 501) and section 305 of the Occupational Disease Act (77 P. S. § 1405) but no longer maintains a current permit.

Security — Security as defined in section 901 of the act.

Self-insurer — A self-insurer as defined in section 901 of the act, including a runoff individual self-insurer and a runoff group self-insurance fund.

Self-insurer accounts — Individual segregated subaccounts of the custodial accounts for the deposit of funds received from security demanded under section 904(d)(2)(ii) of the act (77 P. S. § 1037.4(d)(2)(ii)).

SWIF — The State Workers' Insurance Fund.

SWIF rate — The amount per unit of exposure which SWIF charges for insurance, calculated by multiplying the lost cost charge for a classification by the SWIF lost cost multiplier.

§ 125.203. Default

(a) Upon receipt of information that a self-insurer has failed to pay compensation due under the act or the Occupational Disease Act, the Bureau will investigate whether the failure to pay compensation has occurred and, if it has, determine the reason for that failure.

(b) If the Bureau determines that the failure to pay compensation may be due to the self-insurer's financial inability to pay compensation, the Bureau will notify the self-insurer of its determination and direct the compensation to be paid within 15 days of the receipt of the notice.

(c) If the self-insurer fails to pay the compensation as directed within 15 days, the Bureau will declare the self-insurer in default. The Bureau also may at any time declare a self-insurer to be in default if the self-insurer fails to pay compensation due to a filing for bankruptcy or being declared bankrupt or insolvent.

§ 125.204. Procedures following default

(a) After the Bureau declares a default, it will determine whether the liabilities of the self-insurer exceed or are less than the self-insurer's security.

(b) If the defaulting self-insurer's liabilities are less than the security, the Bureau will notify the custodian of the security that it shall utilize the security to cure the default. The Bureau will monitor payments made by the custodian of the security to ensure that compensation is paid as due under the act or the Occupational Disease Act.

(c) If at any time the defaulting self-insurer's liabilities exceed or can reasonably be expected to exceed the security, the Bureau will order payment of the security into a self-insurer account within the appropriate custodial account. The funds deposited into each self-insurer account and the interest thereon will be used solely for the payment of compensation or costs associated therewith to employes of the defaulting self-insurer providing the security.

(d) After the assets of a self-insurer account have been exhausted, compensation shall be paid from funds obtained through assessments made and collected under section 907 of the act (77 P. S. § 1037.7) and related provisions of this subchapter and interest thereon.

§ 125.205. Allocation of security

When a security instrument posted by a self-insurer applies to claims resulting from injuries and exposures occurring both prior to and on or after the establishment of the guaranty fund, the Bureau may order payment of a portion of the security into a self-insurer account under section 904(d)(2)(ii) of the act (77 P. S. § 1037.4(d)(2)(ii)) for the payment of compensation on claims resulting from injuries and exposures occurring on or after the establishment of the guaranty fund. The portion of the security retained by the custodian of the security shall be used for the payment of compensation on claims resulting from injuries and exposures occurring prior to the establishment of the guaranty fund.

§ 125.206. Payments to claimants

When payment of compensation is ordered by the Bureau from the guaranty fund relating to a defaulting self-insurer, compensation in arrears to the claimants will be paid within 15 days of the issuance of the order. After the initial payment of compensation, compensation will be paid in the same manner as the defaulting self-insurer would be required to make those payments under the act or the Occupational Disease Act.

§ 125.207. Assessment of new individual self-insurer

As a condition for the issuance of a permit to operate as an individual self-insurer under section 305 of the act (77 P. S. § 501), an applicant shall submit to the Bureau the calculation of its modified manual premium on a form prescribed by the Bureau. Following the receipt of the calculation form and the commencement of the applicant's self-insurance status, the Bureau will issue a notice to the new self-insurer assessing it for the guaranty fund based on 1/2% of its modified manual premium. The new self-insurer shall pay the assessment in the time prescribed by the Bureau.

§ 125.208. Assessment of new group self-insurance fund

As a condition for the issuance of a permit to operate as a group self-insurance fund under Article VIII of the act (77 P. S. §§ 1036.1 — 1036.18), an applicant shall submit to the Bureau the calculation of each member's modified manual premium on a form prescribed by the Bureau. Following the receipt of the calculation forms and the commencement of the applicant's group self-insurance status, the Bureau will issue a notice to the new group self-insurance fund assessing it for the guaranty fund based on 1/2% of the total of its members' modified manual premiums. The new group self-insurance fund shall pay the assessment within 30 days of the receipt of the assessment.

§ 125.209. Assessment of new members of group self-insurance fund

As an existing group self-insurance fund adds new members, it shall submit the form prescribed by the Bureau calculating each new member's modified manual premium. Following the receipt of the calculation form, the Bureau will issue to the group self-insurance fund a notice assessing it for the guaranty fund based on 1/2% centum of the total of its new members' modified manual premiums. The group self-insurance fund shall pay the assessment within 30 days of the receipt of the assessment.

§ 125.210. Assessment of existing self-insurer

(a) If the liabilities of the guaranty fund exceed its assets, including funds deposited into the guaranty fund under section 906(a)(1) of the act (77 P. S. § 1037.6(a)(1)), the Bureau may assess self-insurers for the additional amount needed to satisfy the liabilities under section 907(b)(1) of the act (77 P. S. § 1037.7(b)(1)).

(b) The Bureau will give notice to each self-insurer of the amount assessed against the self-insurer under this section. Payment of the assessment shall be made within 30 days of the receipt of the assessment.

(c) Assessment of a self-insurer under section 907(b)(1) of the act shall be determined as follows: the amount of compensation paid by the self-insurer during the preceding calendar year multiplied by the quotient resulting from dividing the amount determined by the Bureau to carry out the requirements of Article IX of the act (77 P. S. §§ 1037.1 — 1037.8) by the total amount of compensation paid by all self-insurers during the preceding calendar year. The amount of compensation paid by the self-insurer and the total amount of compensation paid by self-insurers shall be obtained from the annual reports filed with the Bureau under sections 445 and 446(e) of the act (77 P. S. §§ 1000.1 and 1000.2(e)).

(d) A self-insurer will not be assessed in any one calendar year more than 1% of the compensation paid by that self-insurer during the previous calendar year.

§ 125.211. Objections to assessment

Within 15 days after the receipt of an assessment notice issued against a self-insurer under Article IX of the act (77 P. S. §§ 1037.1 — 1037.8), the self-insurer may file objections with the Bureau if it believes the assessment is excessive, erroneous, unlawful or invalid. The objector shall state in detail the grounds for the objections. The Bureau, after notice to the objector, will hold a hearing upon the objections. After the hearing, the Bureau will record its findings on the objections and will transmit to the objector, by registered mail, notice of the amount, if any, charged against it in accordance with the findings. That amount shall be paid by the objector within 10 days after receipt of notice of the findings unless the objector initiates an action in the appropriate court within 10 days after receipt of the Bureau's notice to restrain the collection or payment of the assessment.

§ 125.212. Calculation of outstanding liability

The Bureau may retain the services of a casualty actuary to project the outstanding liability of the guaranty fund. Fees for actuarial services shall be an expense of the guaranty fund.

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 employes 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.

(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 employes.

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.

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, employes 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.

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 — Ration 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.

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.

(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%.

§ 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.

§ 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.

(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.

(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.

§ 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%.

(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 Form 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%.

(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 lose 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.

(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.

(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.

(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 employes 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 employes 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.

(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.

§ 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).

(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.

(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 cots 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.

§ 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.

§ 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).

(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).

(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.

(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.

§ 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.

§ 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.

(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.

§ 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.

(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 employe; 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.

(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 employe'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 employe'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 employe.

(d) If an insurer, employer or employe 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, employe 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 employe for the work-related injury which is the subject of the UR request, regardless of the period of treatment under review.

§ 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.

(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 employe.

(b) Reviewers shall assume the existence of a causal relationship between the treatment under review and the employe's work-related injury. Reviewers may not consider or decide issues such as whether the employe 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.

§ 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]

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.

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 Workers' 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 Workers' 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.

§ 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.

§ 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 employe 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.

(b) Reviewers shall assume the existence of a causal relationship between the treatment under review and the employe's work-related injury. The reviewer may not consider or decide issues such as whether the employe 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 coursers 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.

§ 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 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 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).

§ 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.

§ 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 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.

(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)).

(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 heath 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 right 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 right 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 acknowledgement 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 acknowledgement to avoid duties specified in the notice.

TITLE 34. LABOR AND INDUSTRY

PART VIII. BUREAU OF WORKERS' COMPENSATION

CHAPTER 129. WORKERS' COMPENSATION HEALTH AND SAFETY

SUBCHAPTER A. PRELIMINARY PROVISIONS

§ 129.1. Purpose

This subchapter provides definitions of terms used in this chapter to allow for accurate understanding of commonly and frequently used terminology.

§ 129.2. Definitions

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

AIPS — Form LIBC-210I, Insurer's Annual Report of Accident and Illness Prevention Services, which provides detailed information about services being maintained or provided by a workers' compensation insurer to its policyholders.

AIPPS — Form LIBC-220E, Annual Report of Accident and Illness Prevention Program Status, which provides detailed information about a self-insured employer's prevention program or prevention services being provided to employer members of a group self-insurance fund.

Accident analysis — The review of injury and illness records for the purpose of identifying trends, causal factors and methods of preventing and reducing work-related accidents and illnesses.

Accident and illness prevention services providers — A person or persons providing accident and illness prevention services for an insurer, individual self-insured employer or group self-insurance fund who meets the requirements in § 129.702 (relating to accident and illness prevention services providers credentials and experience).

Accident and illness prevention services — Services, within the context of the act, which include: surveys, proposed corrective actions, training programs, consultations, analyses of accident causes and industrial hygiene and industrial health services.

Act — The Workers' Compensation Act (77 P. S. §§ 1-1041.4 and 2501-2626).

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

Act 57 — The act of June 24, 1996 (P. L. 350, No. 57).

Adequate — A Bureau of Workers' Compensation final determination that the insurer, individual self-insured employer or group self-insurance fund has fulfilled the program and service requirements as stated in this chapter.

Affiliated company — Employers which are closely related through common ownership or control.

Applicant-employer — An insured employer, an individual self-insured employer or an employer member of a group self-insurance fund having its own separate Federal Employer Identification Number (FEIN) applying to the Bureau for certification or certification renewal of its workplace safety committee.

Application — Form LIBC-372, Application for Certification of Workplace Safety Committee, used to apply for Department certification.

Audit — An inspection of documentation or other evidence relating to the adequacy of accident and illness prevention services or programs as authorized by section 1001(c) of the act (77 P. S. § 1038.1(c)).

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

Centralized workplace safety committee — A safety committee comprised of personnel, both employer and employee representatives, who are selected from and reasonably represent those job functions located at all auxiliary or satellite employer locations, in addition to the headquarter facilities (if the headquarters facility is located in this Commonwealth) and which represents the health and safety concerns of all personnel at those auxiliary or satellite locations.

Certification — The Departmental approval of an applicant-employer's application for certification of its workplace safety committees.

Certification renewal — Form LIBC-372R, Certification Renewal Affidavit of Workplace Safety Committee, used to attest to the continued operation, according to Departmental requirements, of a previously certified workplace safety committee.

Commissioner — The Insurance Commissioner of the Commonwealth.

Consultation — Providing advice relative to existing and potential hazards.

Contracted accident and illness prevention services providers — A person or organization which meets the qualification standards in § 129.702 (relating to accident and illness prevention services providers requirement) under contract with an insurer, individual self-insured employer or group self-insurance fund for the purpose of maintaining or providing accident and illness prevention services and programs as required under the act.

Credential — A designation in the health and safety field recognized by the Department.

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

Director — The Director of the Bureau.

Effectiveness measures — Any one of the various statistical means used by an insurer, self-insured employer or group self-insurance fund to evaluate the adequacy of accident and illness prevention programs and services such as Occupational Health and Safety Administration (OSHA) United States Department of Labor Bureau of Labor Statistics (BLS) incidence rate comparison, loss ratio or experience modification factor.

Emergency action plans — Plans to be at least annually reviewed by individual self-insured employers and which address the need for immediate action to protect employees due to the occurrence of life-threatening or endangering exposures. Examples of types of plans include: building and site evacuation; hazardous material spill; and urgent employee medical treatment.

Evaluation methods — Periodic reviews of accident and illness prevention services or programs to determine if actual health and safety concerns, experience and exposures are being addressed, and conducted at least annually.

Group self-insurance fund — A group of employers authorized by the Bureau to act as a self-insurance fund under section 802 of the act (77 P. S. § 1036.2).

Group self-insurance fund initial report of accident and illness prevention services — A report to be filed with the Bureau when an application for group self-insurance fund status is submitted which details accident and illness prevention services to be maintained for member companies.

Hazard identification methods — Methods used to conduct hazard identification and for providing proposed corrective actions for the purpose of eliminating or reducing occupational accidents, injuries and illnesses. Activities may include: providing solutions; explanations; resources; reference materials; and referrals.

Industrial health services — Services that include a consultation concerning the well-being of people in relation to their job and working environment. This consultation may produce proposed corrective actions aimed at identifying, controlling and preventing exposures as part of the implementation of a program of accident and illness prevention services.

Industrial hygiene services — Services that include consultation concerning suspected chemical, physical or biological exposures. This consultation may produce proposed corrective actions designed to control or prevent identified exposures and is directed toward implementing a program of accident and illness prevention services.

In-service status — The classification granted to an accident and illness prevention services provider who does not possess a Bureau-recognized credential under § 129.702.

Insurer — An entity or group of affiliated entities subject to The Insurance Company Law of 1921 (40 P. S. §§ 341 — 477(d)), including the State Workers' Insurance Fund, but not including self-insured employers or runoff self-insurers, with which an employer has insured its liability under section 305 of the act (77 P. S. § 501).

Insurer's initial report of accident and illness prevention services — Form LIBC-211I, Insurer's Initial Report of Accident and Illness Prevention Services, which shall be filed with the Insurance Department when an insurer applies for a license to write workers' compensation insurance in this Commonwealth which details accident and illness prevention services to be maintained by or provided to policyholders.

Loss run — A report containing an employer's incurred losses including the following information concerning an employee's injury or illness: type; cause; medical cost; compensation paid; and moneys reserved for claim payment.

Member — An employer participating in a group self-insurance fund.

Program coordinator — An employee or contracted individual selected by an individual self-insured employer or group self-insurance fund to coordinate the accident and illness prevention program.

Quorum — A majority of permanent workplace safety committee members.

Recommendations — Findings included in an audit report issued by the Bureau which must be satisfactorily implemented and supported by written documentation in order to achieve a final determination of adequate.

Renewal — A new policy offered by an insurer and accepted by an employer for the next annual anniversary date of the applicant-employer's workers' compensation insurance policy after certification of its workplace safety committee.

SWIF — The State Workers' Insurance Fund.

Self-insured employer — An individual self-insured employer who is authorized by the Department to self-insure its workers' compensation liability under section 305 of the act, or a group of employers authorized by the Department to act as a group self-insurance fund under section 802 of the act.

Self-insured employer's initial report of accident and illness prevention program — A report to be filed with the Bureau when an application for individual self-insurance is submitted which details the accident and illness prevention program to be maintained by the employer.

Suggestions — Findings of an audit or report evaluation issued by the Bureau which would improve accident and illness prevention programs and services but are not mandatory to achieve a final determination of adequate.

Survey — A review of past accident records or an onsite assessment, or both, to identify existing and potential hazards and the initiation of further corrective actions, as appropriate.

Training program — Training which enables employers and employees to enhance knowledge, skills, attitudes and motivations concerning health and safety issues, and requirements relating to operations, processes, materials and specific work environments.

Workplace — A permanent location in this Commonwealth of the applicant-employer at which full-time or permanent part-time workers perform their job duties or from which job assignments are made and administrative controls are exercised.

Workplace safety committee — A joint employer and employee committee established at a workplace for the purpose of hazard detection and accident and illness prevention activities.

Worksite — A temporary location at which full-time or permanent part-time workers perform their job duties for a limited period of time.

SUBCHAPTER B. INSURER'S ACCIDENT AND ILLNESS PREVENTION SERVICES

§ 129.101. Purpose

This subchapter interprets the requirements of the act that an insurer desiring to write workers' compensation insurance in this Commonwealth shall maintain or provide adequate accident and illness prevention services as a prerequisite for a license to write this insurance. Services shall be adequate to furnish accident and illness prevention required by the nature of the insurer's business or its policyholders' operations. This subchapter also establishes the criteria that the Department will employ in determining the adequacy of the services required to be maintained or provided by an insurer.

§ 129.102. Accident and illness prevention services requirements

The Bureau will annually evaluate the following required accident and illness prevention services components for adequacy:

(1) Notice of availability of services. Notice that services required by this subchapter are available to the policyholder from an insurer shall appear in at least 10 point bold type and shall accompany each

workers' compensation insurance policy delivered or issued for delivery in this Commonwealth. The notice shall include information about the 5% premium discount available to employers who form a certified workplace safety committee as described in this chapter. The required elements of the notice include the name, address and telephone number of the contact person or department for additional information about the services.

(2) Requirements to maintain accident and illness prevention services. An insurer shall have the capacity to provide services that are adequate to furnish accident and illness prevention required by the nature of the insurer's business or its policyholders' operations. Capacity to provide services is defined as an insurer having established means to deliver services such as those listed in paragraph (3) based upon anticipated policyholder requests for services or based upon an insurer's evaluation of policyholder requirements. Capacity to provide services shall be established by an insurer utilizing its own or contracted staff who shall meet the requirements established by the Department as outlined in Subchapter E (relating to accident and illness prevention services providers requirements).

(3) Requirements to provide accident and illness prevention services.

(i) An insurer shall provide accident and illness prevention services to policyholders who request them or based on the insurer's determination of the policyholders' operational requirements. Services shall be provided through an insurer's own or contracted staff who meet the requirements established by the Department in Subchapter E.

(ii) Services include the following:

(A) Surveys to identify existing or potential accident and illness hazards or safety program deficiencies. Surveys may, for example, be in the form of an underwriting risk analysis or an onsite review. If the insurer determines through a survey and analysis of survey results that the hazards or deficiencies are present, it shall propose corrective actions to the policyholder concerning the abatement of hazards or program deficiencies identified in the surveys. If one or more imminent danger situations are identified, the insurer shall inquire as to the corrective actions a policyholder has taken and propose further corrective actions if necessary.

(B) Providing or proposing corrective actions in the area of industrial hygiene services as requested by the policyholder or as determined by the insurer to meet the policyholders' operational requirements for example, air quality testing.

(C) Providing or proposing corrective actions in the area of industrial health services as requested by the policyholder or as determined by the insurer to meet the policyholders' operational requirements, for example, health screenings or substance abuse awareness and prevention training policies and programs.

(D) Accident and illness prevention training programs which may include training for safety committee members as outlined under Subchapter F (relating to workplace safety committees).

(E) Consultations regarding specific safety and health problems and hazard abatement programs and techniques related to the introduction of new equipment or new materials.

§ 129.103. Obligation of an insured employer/policy holder

An insured employer/policyholder requesting accident and illness prevention services as mandated by the act shall provide the necessary information and access to the insurer to permit the insurer to fulfill its requirements under the act.

§ 129.104. Insurer's accident and illness prevention services providers requirements

(a) Accident and illness prevention services providers employed by or contracted with an insurer to perform accident and illness prevention services shall meet the requirements specified in Subchapter E (relating to accident and illness prevention services providers requirements).

(b) The Bureau may require that the insurer provide documentation or evidence to support that the requirements for accident and illness prevention services providers have been met by each individual providing accident and illness prevention services, whether employed or under contract, based on the criteria in Subchapter E.

§ 129.105. Reporting requirements for applicants for licensure

(a) As part of their application for a certificate of authority submitted to the Insurance Department, applicants for a license to write workers' compensation insurance shall provide information concerning their accident and illness prevention services required under § 129.102 (relating to accident and illness prevention services requirements) using Form LIBC-211I, Insurer's Initial Report of Accident and Illness Prevention Services.

(b) As part of the process of licensing to write workers' compensation insurance in this Commonwealth, the Insurance Department will forward to the Bureau the report in subsection (a) for a determination of adequacy. The Bureau will provide a final determination of adequate or inadequate to the Commissioner.

§ 129.106. Reporting requirements for licensed insurers

A licensed insurer shall, by June 1 of each year, provide the Bureau with information concerning accident and illness prevention services offered or provided to the insurer's policyholders during the preceding calendar year. The information shall be provided using the AIPS report. In addition, documentation required by other governmental regulatory agencies can be used as supporting evidence of accident and illness prevention services. Report information shall be subject to Bureau verification.

§ 129.107. Report findings

(a) Upon receipt of a report required under § 129.105 (relating to reporting requirements applicants for licensure), the Bureau will review the report data, make a final determination of the adequacy or inadequacy of services and provide notification to the Commissioner and the insurer of its final determination.

(b) Upon receipt of a report required under § 129.106 (relating to reporting requirements for licensed insurers), the Bureau will review the report data and make a final determination of adequacy or an initial determination of inadequacy of services. An inadequate determination may result in an audit of services before a final determination is made. The Bureau will provide notification to the Commissioner and the insurer of its final determination.

§ 129.108. Recordkeeping requirements

Insurers shall maintain records of accident and illness prevention services by a policyholder for the most complete current calendar year and 2 preceding consecutive calendar years which include:

(1) The dates of the requests for services.

(2) The services requested or problems presented.

(3) Reports from site inspections performed.

(4) Other service reports including proposed corrective actions.

(5) The dates on which services were provided and the policyholder's responses to proposed corrective actions.

(6) The results of industrial hygiene and health surveys and consultations.

(7) Accident and illness prevention training conducted.

(8) Documentation supporting the funds expended for the delivery of accident and illness prevention services.

(9) Evidence of the effectiveness and accomplishments of accident and illness prevention services.

§ 129.109. Periodic audits of insurer's accident and illness prevention services

(a) The Bureau may audit an insurer's accident and illness prevention services at least once every 2 years.

(b) The Bureau may audit an insurer's accident and illness prevention services if the insurer fails to file an AIPS by specified time frames or fails to meet the requirements of this subchapter.

(c) The notice of the audit will include the reasons for audit.

(d) At least 60-calendar days prior to an audit, the Bureau will notify the insurer in writing of the date on which the audit will occur.

§ 129.110. Preaudit exchange of information

(a) At least 45-calendar days prior to the audit, the insurer shall provide the Bureau with:

(1) If not already submitted, a completed, annual AIPS report for the most recently completed calendar year and, if requested, the AIPS reports for the 2 preceding consecutive calendar years including those of its affiliated companies, if applicable.

(2) A description of the type of accident and illness prevention services provided during the last completed calendar year and a list of current insured employers/policyholders specifying name and premium size grouping which: received services; requested but did not receive services; and have reported to the carrier that they have a certified workplace safety committee.

(3) The name, address, business telephone number, credentials, experience and status (whether employed or contracted) of each person acting as an accident and illness prevention services provider for the insurer.

(b) The Bureau will keep the list of insured employers/policyholders confidential.

(c) Within 10-calendar days of receipt of the list of policyholders, the Bureau will notify the insurer of the accounts selected for audit and the information required concerning these accounts.

(d) At least 15-calendar days prior to the date of the audit, the insurer shall provide the account information referenced in subsection (c) to the Bureau.

(e) If the information necessary for the audit is not furnished, the Bureau may cancel the audit, and a final determination of inadequate will be forwarded to the Director. The Director will provide notification to the Commissioner and to the insurer of its final determination. A rating may be challenged by the insurer in accordance with Subchapter G (relating to hearings).

§ 129.111. Site of audit

(a) The audit of the insurer's accident and illness prevention services will take place at the insurer's main office in this Commonwealth unless otherwise agreed by the Bureau and the insurer. If the insurer has no office in this Commonwealth, the audit will take place at the Bureau's headquarters.

(b) At the site where the audit will occur, the insurer shall provide the documentation required by § 129.108 (relating to record keeping requirements) and any other documentation chosen by the insurer supporting the existence and adequacy of required services.

§ 129.112. Written report of audit

(a) After the conclusion of the audit, the Bureau will issue a written report containing its findings. The report will indicate whether the Bureau has issued a final determination of adequate or an initial determination of inadequate with regard to an insurer's accident and illness prevention services.

(b) The Bureau will notify the insurer of a final determination of adequate.

(c) The Bureau will provide written notification to the insurer of specific deficiencies and recommendations for corrective action if it assigns an initial determination of inadequate. Within 60-calendar days from the date of the audit report, the insurer shall provide written documentation that it has complied with the Bureau's recommendations. If the insurer believes that it will take more than 60 days to implement the recommendations, it shall file a plan of correction in accordance with § 129.113 (relating to plan of correction/reports of progress on correcting deficiencies). At the end of the 60-calendar day correction period, a final determination of adequate or inadequate will be assigned. The insurer will receive notification of this final determination. The Commissioner will receive notification of final determinations of inadequate.

§129.113. Plan of correction/reports of progress on correcting deficiencies

An insurer shall file a plan of correction to implement audit report recommendations referenced in § 129.112(c) (relating to written report of audit) for any deficiency requiring more than 60 days to correct. The plan shall include a timetable for correction acceptable to the Bureau. Progress reports shall be filed by the insurer detailing corrective actions at the end of each 30-day period of the correction plan period. The Bureau

may audit the insurer's accident and illness prevention services if the insurer fails to file progress reports, implement recommendations, or provide acceptable documentation of corrective actions. At the end of the correction plan period, a final determination of adequate or inadequate will be made, and the insurer will be notified of the determination. The Commissioner will be notified of final determinations of inadequate.

§ 129.114. Contesting final determinations

An insurer may contest a final determination of inadequate under Subchapter G (relating to hearings).

SUBCHAPTER C. INDIVIDUAL SELF-INSURED EMPLOYER'S ACCIDENT AND ILLNESS PREVENTION PROGRAMS

§ 129.401. Purpose

This subchapter interprets the requirements of the act that an individual self-insured employer shall maintain an adequate accident and illness prevention program as a prerequisite for retention of its self-insured status. The subchapter establishes the criteria that the Bureau will employ in determining the adequacy of the accident and illness prevention program required to be maintained by an individual self-insured employer.

§ 129.402. Program requirements

(a) An individual self-insured employer shall maintain an adequate accident and illness prevention program and maintain records for this program for the 3 most current, complete fiscal years. The program shall include the following elements:

(1) A safety policy statement.

(2) A designated accident and illness prevention program coordinator.

(3) Assignment of responsibilities for developing, implementing and evaluating the accident and illness prevention program.

(4) Program goals and objectives.

(5) Methods for identifying and evaluating hazards and developing corrective actions for their mitigation.

(6) Industrial hygiene surveys required by the nature of the individual self-insured employer's workplace and worksite environments, for example, air quality testing.

(7) Industrial health services required by the nature of the individual self-insured employer's workplace environment, for example, health screenings, substance abuse awareness and prevention training programs.

(8) Accident and illness prevention orientation and training.

(9) Regularly reviewed and updated emergency action plans.

(10) Employee accident and illness prevention suggestion and communications programs.

(11) Mechanisms for employee involvement, which may include establishment of a workplace safety committee as described in Subchapter F (relating to workplace safety committees).

(12) Established safety rules and methods for their enforcement.

(13) Methods for accident investigation, reporting and recordkeeping.

(14) Prompt availability of first aid, CPR and other emergency treatments.

(15) Methods for determining and evaluating program effectiveness. These may include:

(i) Comparison of the individual self-insured employer's incidence rate as derived using the OSHA/BLS formula to the current OSHA/BLS industry-wide rate published annually in the BLS Survey of Occupational Injuries and Illnesses.

(ii) Comparison of individual employer injury and illness rates determined by means of a formula prescribed by the Bureau to current, Statewide rates by industry published annually by the Bureau in the Pennsylvania Work Injuries and Illnesses Report.

(iii) Experience modification factor.

(iv) Loss ratio.

(v) Other methods used by individual self-insured employers deemed appropriate by the Bureau.

(16) Protocols or standard operating procedures, when applicable to the workplace and worksite environments for:

(i) Electrical and machine safeguarding.

(ii) Personal protective equipment.

(iii) Hearing and sight conservation.

(iv) Lockout/tagout procedures.

(v) Hazardous materials handling, storage and disposal procedures.

(vi) Confined space entry procedures.

(vii) Fire prevention and control practices.

(viii) Substance abuse awareness and prevention policies and programs.

(ix) Control of exposure to bloodborne pathogens.

(x) Preoperational process reviews.

(xi) Other protocols as may be appropriate for the individual self-insured employer's operations.

(b) Individual self-insured employers shall maintain records describing the comparison methods chosen from subsection (a)(15) for the most current complete fiscal year and 2 preceding consecutive fiscal years. Those records shall contain at a minimum:

(1) The annual calculated rates for the methods chosen.

(2) A copy of the calculations used to determine the annual rates.

(3) A copy of the sources containing the complete data used in calculating the annual rates.

§ 129.403. Individual self-insured employer's accident and illness prevention services providers requirements

(a) Accident and illness prevention services providers employed by an individual self-insured employer or serving through a contract to perform accident and illness prevention services shall meet the requirements in Subchapter E (relating to accident and illness prevention services providers requirement).

(b) The Bureau may require that the individual self-insured employer provide documentation or evidence to support that the requirements for accident and illness prevention services providers have been met by each individual providing accident and illness prevention services, whether employed or under contract, based on the criteria in Subchapter E.

§ 129.404. Reporting requirements for applicants for individual self-insurance status

(a) As part of its application for individual self-insurance status submitted to the Bureau, an applicant for individual self-insurance status shall provide the Bureau with detailed information on its accident and illness prevention program as required under § 129.402 (relating to program requirements) using form LIBC-221E, Initial Report of Accident and Illness Prevention Program.

(b) As part of the process of granting individual self-insurance status, the Bureau will use this information to determine whether to grant individual self-insurance status.

§ 129.405. Reporting requirements for individual self-insured employers

(a) At the time of reapplication for renewal of self-insurance status, an individual self-insured employer shall, as required under section 815 of the act (77 P. S. § 1036.15), provide the Bureau with detailed information on its accident and illness prevention program using the AIPPS report, for the last complete fiscal year preceding the date of the renewal application.

(b) In addition, documentation required by other governmental regulatory agencies can be used as supporting evidence of accident and illness prevention programs.

(c) Report information shall be subject to Bureau verification.

§ 129.406. Report findings

Upon receipt of a report required under § 129.404 (relating to reporting requirements for individual self-insurance status employers), the Bureau will review the report data and make a final determination of adequacy or an initial determination of inadequacy of programs. An inadequate determination may result in an audit of services before a final determination is made. The Bureau will provide notification to the employer of its final determination.

§ 129.407. Recordkeeping requirements

Individual self-insured employers shall maintain records of accident and illness prevention program services for the most complete fiscal year and 2 preceding consecutive fiscal years which include:

(1) Number and dates of surveys conducted.

(2) Proposed corrective actions and their disposition.

(3) Training programs conducted.

(4) Consultations held.

(5) Analyses of accident causes.

(6) Industrial hygiene services provided.

(7) Industrial health services provided.

(8) Qualified service providers utilized to provide program services whether contracted or employed.

§ 129.408. Periodic audits of individual self-insured employer's accident and illness prevention program

(a) The Bureau may audit an individual self-insured employer's accident and illness prevention program at least once every 2 years.

(b) A combined audit may be conducted for affiliated companies of an individual self-insured employer if the same facilities, accident and illness prevention program, and accident and illness prevention services providers are used by each of the companies.

(c) The Bureau may audit an individual self-insured employer's accident and illness prevention program if the individual self-insured employer fails to file an AIPPS by specified time frames or fails to meet the requirements of this subchapter.

(d) The notice of the audit will include the reasons for audit.

(e) At least 60 calendar days prior to an audit, the Bureau will notify the individual self-insured employer in writing of the date on which the audit will occur.

§ 129.409. Preaudit exchange of information

(a) At least 45-calendar days prior to the audit, the individual self-insured employer shall provide the Bureau with:

(1) If not already submitted, a completed annual AIPPS report for the most recently completed fiscal year and, if requested, the AIPPS reports for the 2 preceding consecutive fiscal years including those of its affiliated companies, if applicable.

(2) The name, address and telephone number of the contact person.

(3) A description of the types of accident and illness prevention program services provided during the last completed fiscal year.

(4) The name, address, business telephone number, credentials, experience and status (whether employed or contracted) of each person acting as an accident and illness prevention services provider for the individual self-insured employer.

(b) At least 15-calendar days prior to the date of the audit, the individual self-insured employer shall provide the Bureau with information on forms prescribed by the Bureau that describe the employer's accident and illness prevention program.

(c) If the information necessary for the audit is not furnished, the Bureau may cancel the audit, and a final determination of inadequate will be forwarded to the Director. The Director will provide notification of its final determination to the employer and initiate appropriate action regarding continuance of self-insurance status. A final determination of inadequate may be challenged by the individual self-insured employer in accordance with Subchapter G (relating to hearings).

§ 129.410. Site of audit

(a) The audit of the individual self-insured employer's accident and illness prevention program will take place at the employer's main office in this Commonwealth unless otherwise agreed by the Bureau and the employer. If the individual self-insured employer has no office in this Commonwealth, the audit will take place at the Bureau's headquarters.

(b) At the site where the audit will occur, the individual self-insured employer shall provide the documentation required by § 129.406 (relating to report findings) and any other documentation chosen by the employer supporting the existence and adequacy of required program elements.

§ 129.411. Written report of audit

(a) After the conclusion of the audit, the Bureau will issue a written report containing its findings. The report will indicate whether the Bureau has issued a final determination of adequate or an initial determination of inadequate with regard to an individual self-insured employer's accident and illness prevention program.

(b) The Bureau will notify the individual self-insured employer of a final determination of adequate.

(c) The Bureau will provide written notification to the individual self-insured employer of specific deficiencies and recommendations for corrective action if it assigns an initial determination of inadequate. Within 60 calendar days from the date of the audit report, the individual self-insured employer shall provide written documentation that it has complied with the Bureau's recommendations. If the individual self-insured employer believes that it will take more than 60 days to implement the recommendations, it shall file a plan of correction in accordance with § 129.412 (relating to plan of correction/reports of progress on correcting deficiencies). At the end of the 60 calendar day correction period, a final determination of adequate or inadequate will be assigned. The individual self-insured employer will receive notification of this final determination.

§ 129.412. Plan of correction/reports of progress on correcting deficiencies

An individual self-insured employer shall file a plan of correction to implement audit report recommendations referenced in § 129.411(c) (relating to written report of audit) for any deficiency requiring more than 60 days to correct. The plan shall include a timetable for correction acceptable to the Bureau. Progress reports shall be filed by the individual self-insured employer detailing corrective actions at the end of each 30-day period of the correction plan period. The Bureau may audit an individual self-insured employer's accident and illness prevention program if an individual self-insured employer fails to file progress reports, implement recommendations or provide acceptable documentation of corrective actions. At the end of the correction plan period, a final determination of adequate or inadequate will be made, and the individual self-insured employer will be notified of the determination.

§ 129.413. Contesting final determinations

An individual self-insured employer may contest a final determination of inadequate under Subchapter G (relating to hearings).

SUBCHAPTER D. GROUP SELF-INSRANCE FUND'S ACCIDENT AND ILLNESS PREVENTION PROGRAMS

§ 129.451. Purpose

This subchapter establishes the criteria that the Bureau will employ in determining the adequacy of the accident and illness prevention program required by a group self-insurance fund under the act as a prerequisite for retention of group self-insurance fund status.

§ 129.452. Program requirements

(a) A group self-insurance fund shall maintain or provide an adequate accident and illness prevention program and maintain records for this program for the 3 most current fiscal years. The program shall contain the following elements:

(1) A safety policy statement.

(2) A designated accident and illness prevention program coordinator.

(3) An assignment of responsibilities for implementing and evaluating the accident and illness prevention program.

(4) Program goals and objectives.

(5) Mechanisms for employee involvement, which may include establishment of a workplace safety committee including a safety committee as described in Subchapter F (relating to workplace safety committees).

(6) Employee accident and illness prevention suggestion and communications programs.

(7) Methods for accident investigation, reporting and recordkeeping.

(8) Methods for determining and evaluating program effectiveness. These may include:

(i) Comparison of the group self-insurance fund incidence rate as derived using the OSHA/BLS formula to the current, published OSHA/BLS industry-wide rate.

(ii) Comparison of the group self-insurance fund injury and illness rates determined by means of a formula prescribed by the Bureau to current, published Statewide rates by industry.

(iii) Experience modification factor.

(iv) Loss ratio.

(v) Other methods used by group self-insurance funds deemed appropriate by the Bureau.

(9) Protocols or standard operating procedures, when applicable, to the workplace and worksite environments for:

(i) Electrical and machine safeguarding.

(ii) Personal protective equipment.

(iii) Hearing and sight conservation.

(iv) Lockout/tagout procedures.

(v) Hazardous materials handling, storage and disposal procedures.

(vi) Confined space entry procedures.

(vii) Fire prevention and control practices.

(viii) Substance abuse awareness and prevention policies and programs.

(ix) Control of exposure to bloodborne pathogens.

(x) Preoperational process reviews.

(xi) Other protocols or standard operating procedures appropriate for members' workplace and worksite operations.

(b) Group self-insurance funds shall maintain records describing the comparison methods chosen from subsection (a)(8) for the most current fiscal year and 2 preceding consecutive fiscal years. Those records shall contain at a minimum:

(1) The annual calculated rates for the methods chosen.

(2) A copy of the calculations used to determine the annual rates.

(3) A copy of the sources containing the complete data used in calculating the annual rates.

§ 129.453. Group self-insurance fund accident and illness prevention services providers requirements

(a) Accident and illness prevention services providers employed by a group self-insurance fund or serving through a contract to perform accident and illness prevention services shall meet the requirements specified in Subchapter E (relating to accident and illness prevention services providers requirements).

(b) The Bureau may require the group self-insurance fund to provide documentation or evidence to support that the requirements for accident and illness prevention services providers have been met by each individual providing accident and illness prevention services, whether employed or under contract, based on the criteria in Subchapter E.

§ 129.454. Reporting requirements for applicants for group self-insurance fund status

(a) As part of its application for group self-insurance fund status submitted to the Bureau, an applicant for self-insurance fund status shall provide the Bureau with detailed information on its accident and illness prevention program that will be offered or provided to group self-insurance fund members as required under § 129.452 (relating to program requirements) using form LIBC-231G, Initial Report of Accident and Illness Prevention Program Status.

(b) As part of the process of granting group self-insurance fund status, the Bureau will use this information to determine whether to grant group self-insurance fund status.

§ 129.455. Reporting requirements for group self-insurance funds

(a) A group self-insurance fund shall provide the Bureau with detailed information on its accident and illness prevention program using the AIPPS report along with the annual report to the Bureau required under section 815 of the act (77 P. S. § 1036.15).

(b) A group self-insurance fund shall also provide information describing the established methods used to identify individual group self-insurance fund members requiring accident and illness prevention services. A group self-insurance fund shall also provide data describing accident and illness prevention services efforts for the identified members and the effectiveness of these efforts in improving injury and illness rates.

(c) In addition, documentation required by other governmental regulatory agencies can be used as supporting evidence of accident and illness prevention programs.

(d) Report information shall be subject to Bureau verification.

§ 129.456. Report findings

(a) Upon receipt of a report required under § 129.454 (relating to reporting requirements applicants for group self-insurance fund status), the Bureau will review the report data and make a final determination of the adequacy or inadequacy of programs and provide notification to the group self-insurance fund applicant.

(b) Upon receipt of a report required under § 129.455 (relating to reporting requirements for group self-insurance funds), the Bureau will review the report data and make a final determination of adequacy or an initial determination of inadequacy of programs. An inadequate determination may result in an audit of programs before a final determination is made. The Bureau will provide notification to the group self-insurance fund of its final determination.

§ 129.457. Service requirements

A group self-insurance fund shall maintain or provide through its own or contracted accident and illness prevention services providers the following accident and illness prevention services to members:

(1) Onsite surveys to identify existing or potential accident and illness hazards or safety program deficiencies. If through a survey and analysis of survey results it is determined that the hazards or deficiencies are present, corrective actions shall be proposed to the group self-insurance fund member concerning the abatement of hazards or program deficiencies identified in the surveys. If one or more imminent danger situations or program deficiencies are identified, the group self-insurance fund shall inquire as to the corrective actions the group self-insurance fund member has taken and propose further corrective actions if necessary.

(2) Analyses of the causes of accidents and illnesses at the members' worksites.

(3) Providing or proposing corrective actions in the area of industrial hygiene services as requested by the group self-insurance fund member or as determined by the group self-insurance fund to meet the group self-insurance fund members' operational requirements, for example, air quality testing.

(4) Providing or proposing corrective actions in the area of industrial health services as requested by the group self-insurance fund member or as determined by the group self-insurance fund to meet the group self-insurance fund members' operational requirements, for example, health screenings or substance abuse awareness and prevention training policies and programs.

(5) Accident and illness prevention training programs which may include training for safety committee members as outlined under Subchapter F (relating to workplace safety committees).

(6) Consultations regarding specific safety and health problems and hazard abatement programs and techniques.

(7) Review of planned or newly introduced industrial materials, processes, equipment, layouts and techniques to identify potential hazards and to recommend methods to mitigate any hazards identified.

§ 129.458. Recordkeeping requirements

(a) Group self-insurance funds shall maintain records of accident and illness prevention programs or services for each member for the most complete current fiscal year and 2 preceding consecutive fiscal years which include:

(1) The dates of requests for services.

(2) The services requested or problems presented.

(3) The dates of the group self-insurance fund's responses.

(4) The dates on which services were provided and member responses to proposed corrective actions.

(5) The number of hours expended providing services including both onsite and preparatory time.

(6) The final disposition of requests.

(7) The number of service visits.

(8) Other service reports including proposed corrective actions.

(9) The results of industrial hygiene and industrial health surveys and consultations.

(10) Accident and illness prevention training conducted.

(11) Safety-related materials provided.

(12) Member responses to group self-insurance fund proposed corrective actions.

(b) Group self-insurance funds shall annually solicit comments from their members regarding the effectiveness of the accident and illness prevention program provided by the group self-insurance fund. This information shall be made available to the Bureau upon request for the next current fiscal year and 2 preceding consecutive fiscal years.

§ 129.459. Periodic audits of group self-insurance fund's accident and illness prevention program

(a) The Bureau may audit a group self-insurance fund's accident and illness prevention program at least once every 2 years.

(b) The Bureau may audit a group self-insurance fund's accident and illness prevention program if the group self-insurance fund fails to file an AIPPS report by specified time frames or meet the requirements of this subchapter.

(c) A combined audit may be conducted for affiliated companies of a group self-insurance fund if the same facilities, accident and illness prevention program, and accident and illness prevention services are used by each of the companies.

(d) The notice of the audit will include the reasons for audit.

(e) At least 60-calendar days prior to an audit, the Bureau will notify the group self-insurance fund administrator in writing of the date on which the audit will occur.

§ 129.460. Preaudit exchange of information

(a) At least 45-calendar days prior to the audit, the group self-insurance fund administrator shall provide the Bureau with:

(1) If not already submitted, a completed annual AIPPS report as prescribed by the Bureau for the most recently completed fiscal year and, if requested, the AIPPS reports for 2 preceding consecutive fiscal years including those of its affiliated companies, if applicable.

(2) A list of the group self-insurance fund members, including the company name, address, telephone number and contact person.

(3) The types of accident and illness prevention program services provided to selected group self-insurance fund members during the last completed group self-insurance fund fiscal year.

(4) The name, address, business telephone number, credentials, experience and status (whether employed or contracted) of each person acting as an accident and illness prevention services provider for the group self-insurance fund.

(b) The Bureau will keep the list of group self-insurance fund members confidential.

(c) At least 15-calendar days prior to the date of the audit, the group self-insurance fund administrator shall provide the Bureau with information on forms prescribed by the Bureau that describe the selected group self-insurance fund member's accident and illness prevention program.

(d) If the information necessary for the audit is not furnished, the Bureau may cancel the audit, and a final determination of inadequate will be forwarded to the Director. The Director will notify the group self-insurance fund administrator of its final determination and initiate appropriate action regarding continuance of group self-insurance fund status. A final determination of inadequate may be challenged by the group self-insurance fund administrator in accordance with Subchapter G (relating to hearings).

§ 129.461. Site of audit

(a) The audit of the group self-insurance fund's accident and illness prevention program will take place at the group self-insurance fund administrator's main office in this Commonwealth unless otherwise agreed by the Bureau and the group self-insurance fund administrator. If the group self-insurance fund has no office in this Commonwealth, the audit will take place at the Bureau's headquarters.

(b) At the site where the audit will occur, the group self-insurance fund shall provide the documentation required by § 129.458 (relating to recordkeeping requirements) and any other documentation chosen by the group self-insurance fund supporting the existence and adequacy of required program elements.

§ 129.462. Written report of audit

(a) After the conclusion of the audit, the Bureau will issue a written report containing its findings. The report will indicate whether the Bureau has issued a final determination of adequate or an initial determination of inadequate with regard to a group self-insurance fund's accident and illness prevention program.

(b) The Bureau will notify the group self-insurance fund administrator of a final determination of adequate.

(c) The Bureau will provide written notification to the group self-insurance fund administrator of specific deficiencies and recommendations for corrective action if it assigns an initial determination of inadequate. Within 60-calendar days from the date of the audit report, the group self-insurance fund shall provide written documentation that it has complied with the Bureau's recommendations.

If the group self-insurance fund believes that it will take more than 60 days to implement the recommendations, it shall file a plan of correction in accordance with § 129.463 (relating to plan of correction/reports of progress on correcting deficiencies). At the end of the 60-calendar-day correction period, a final determination of adequate or inadequate will be assigned. The group self-insurance fund administrator will receive notification of this final determination.

§ 129.463. Plan of correction/reports of progress on correcting deficiencies

A group self-insurance fund shall file a plan of correction to implement audit report recommendations referenced in § 129.462(c) (relating to written report of audit) for any deficiency requiring more than 60 days to correct. The plan shall include a timetable for correction acceptable to the Bureau. Monthly progress reports shall be filed by the group self-insurance fund detailing corrective actions at the end of each 30-day period of the correction plan period. The Bureau may audit a group self-insurance fund's accident and illness prevention program if the group self-insurance fund fails to file progress reports, implement recommendations, or provide acceptable documentation of corrective actions. The group self-insurance fund will be notified of the determinations made by the Bureau.

§ 129.464. Contesting final determinations

A group self-insurance fund administrator may contest a final determination of inadequate under Subchapter G (relating to hearings).

SUBCHAPTER E. ACCIDENT AND ILLNESS PREVENTION SERVICES PROVIDERS REQUIREMENTS

§ 129.701. Purpose and scope

This subchapter sets forth the requirements for accident and illness prevention services providers. These requirements apply only to those individuals either directly employed by or retained under contract with either a workers' compensation insurer, individual self-insured employer or group self-insurance fund and who provide accident and illness prevention services for the workers' compensation insurers' policyholders, the individual self-insured employer or group self-insurance fund members. Procedures by which organizations and associations may apply for recognition of credentials are also outlined.

§ 129.702. Accident and illness prevention services providers requirements

(a) A workers' compensation insurer, individual self-insured employer or group self-insurance fund shall directly employ accident and illness prevention services providers or shall retain contracted accident

and illness prevention services providers who meet the requirements as described in this section to provide accident and illness prevention services.

(b) An individual providing accident and illness prevention services as an employee or contracted accident and illness prevention services provider shall supply annual proof of current credentials and experience to the insurer, individual self-insured employer or group self-insurance fund.

(c) An insurer, individual self-insured employer or group self-insurance fund administrator shall be responsible for reviewing the documentation or evidence to support that the requirements for accident and illness prevention services providers are being met according to the criteria in subsection (d). Verification that requirements have been met by all employed or contracted accident and illness prevention services providers utilized to provide accident and illness prevention services during the reporting period shall be submitted to the Bureau as part of the annual reports.

(d) An individual shall be recognized as an accident and illness prevention services provider within the meaning of section 1001(a) and (b) of the act (77 P. S. § 1038.1(a) and (b)) and this subchapter, by providing verification that the individual meets one or more of the following requirements:

(1) An educational degree or credential recognized by the Bureau in accident and illness prevention fields from accredited institutions or programs and at least 2 years of acceptable experience as set forth in subsection (e).

(2) A credential recognized by the Bureau from a professional organization in the field of accident and illness prevention and at least 2 years of acceptable experience as set forth in subsection (e).

(3) A credential from an industry-specific accident and illness prevention program recognized by the Bureau and at least 2 years of acceptable experience as set forth in subsection (e). Holders of recognized credentials will be restricted to the delivery of accident and illness prevention services as defined by the specific program within a given industry.

(e) The 2 years of accident and illness prevention experience required in subsection (d) shall include current, full-time professional experience providing accident and illness prevention services which accounts for at least 60% of the individual's activities. Acceptable activities include: identifying hazards; conducting safety and health surveys; proposing corrective actions; analyzing accident causes; and recommending or providing industrial hygiene and industrial health surveys and consultations.

(f) The Bureau will maintain a listing of recognized organizational credentials. Inquiries may be made to the Bureau for current information reflecting additions or deletions to that listing.

(g) An insurer, individual self-insured employer or group self-insurance fund can request in-service status for a services provider utilized to provide services for a given reporting period, but who does not meet Bureau requirements as outlined in subsection (d) and has not been previously granted in-service status. Providers granted in-service status shall have 5 years from the filing date of the annual report in which the request for in-service status was made to meet Bureau requirements as outlined in subsection (d). The activities of accident and illness prevention services providers claiming in-service status shall be directed by a services provider who meets the requirements of this subchapter during the 5-year period in which a recognized credential is being earned and required experience is being obtained. After that 5-year period, an individual who has not met Bureau requirements and submitted acceptable proof to the Bureau, through the employing or contracting insurer, individual self-insured employer or group self-insurance fund may not be recognized as an accident and illness prevention services provider for purposes of the act.

§ 129.703. Proof of accident and illness prevention services providers credentials and experience

Proof of an individual's credentials and experience as an accident and illness prevention services provider shall be maintained by the insurer, individual self-insured employer or group self-insurance fund. For audit purposes, the proof of credentials and experience for each accident and illness prevention services provider shall be retained for the most complete current year and 2 preceding consecutive years.

§ 129.704. Procedures for obtaining credential recognition

The Bureau will accept applications from educational programs, credentialing organizations or specific industry programs requesting recognition of credentials awarded by the organization. Form and content of applications will be specified by the Bureau.

§ 129.705. Contesting denial of credential recognition or recognition as a qualified accident and illness prevention services provider

(a) An organization may contest a denial of credential recognition under Subchapter G (relating to hearings).

(b) An insurer, individual self-insured employer or group self-insurance fund may contest a denial or recognition as a qualified accident and illness prevention services provider under Subchapter G.

SUBCHAPTER F. WORKPLACE SAFETY COMMITTEES

§ 129.1001. Purpose

This subchapter sets forth the certification criteria for the operation of workplace safety committees established for the purpose of accident and illness prevention An applicant-employer shall meet the criteria in this subchapter to obtain certification or certification renewal of its workplace safety committees for its workplaces within this Commonwealth.

§ 129.1002. Application for initial certification

(a) An applicant-employer desiring to apply for certification of its workplace safety committee shall file form LIBC-372, Application for Certification of Workplace Safety Committee, with the Bureau. An application shall be filed for each legal entity of the applicant-employer and shall include all information and documentation requested in form LIBC-372.

(b) An applicant-employer shall file one application which shall incorporate all of the applicable applicant-employer workplaces within this Commonwealth.

(c) Applications shall be submitted to the Bureau between 90 — and 30-calendar days prior to the annual renewal of a workers' compensation policy, self-insurance renewal year or group self-insurance fund year.

§ 129.1003. Minimum eligibility requirements

(a) An applicant-employer's committees shall be located within this Commonwealth.

(b) The committee shall be in existence and operating according to the requirements of this subchapter for 6 full, consecutive calendar months prior to the signing, dating and submission of the application.

(c) The committee membership shall represent all primary operations of the workplace.

(d) The committees shall be composed of a minimum of two employer-representatives and a minimum of two employee-representatives.

(e) Employer-representatives are individuals who, regardless of job title or labor organization affiliation, and based upon an examination of that individual's authority or responsibility, do one or more of the following:

(1) Select or hire an employee.

(2) Remove or terminate an employee.

(3) Direct the manner of employee performance.

(4) Control the employee.

(f) Employee-representatives are individuals who perform services for an employer for valuable consideration and do not possess any authority or responsibility described in subsection (e).

(g) A person may not function as both an employer-representative and an employee-representative.

§ 129.1004. Committee formation and membership

(a) An applicant-employer who has only one workplace within this Commonwealth shall form a single workplace safety committee at that workplace within this Commonwealth for certification.

(b) An applicant-employer who has more than one workplace within this Commonwealth may form either a single, centralized workplace safety committee representing each of its workplaces within this Commonwealth or separate and individual safety committees at each workplace within this Commonwealth for certification.

(c) The committee shall be composed of at least an equal number of applicant-employer and employee-representatives unless otherwise agreed upon by both parties. An applicant-employer shall provide a satisfactory, written explanation to the Bureau when a committee is not composed of an equal number of applicant-employer and employee-representatives and a majority of applicant-employer representatives exists. The explanation shall be signed by one employer and one employee committee representative.

(d) Workplace safety committees shall establish procedures that retain a core group of experienced members to serve on the committee at all times.

(e) Employee-representatives of the committees shall:

(1) Be permitted to take reasonable time from work to perform committee duties, without loss of pay or benefits.

(2) Join the committee for a continuous term of 1 year from the date of the first meeting attended. Records of member rotation shall be maintained by the applicant-employer for 5 years from the date of the Bureau's receipt of the application.

§ 129.1005. Committee responsibilities

(a) To qualify for certification, workplace safety committees shall have responsibilities including:

(1) Representing the accident and illness prevention concerns of employees at every applicant-employer workplace.

(2) Reviewing the applicant-employer's hazard detection and accident and illness prevention programs and formulating written proposals.

(3) Establishing procedures for periodic workplace inspections by the safety committees for the purpose of locating and identifying health and safety hazards. The locations and identity of hazards shall be documented in writing, and the committees shall make proposals to the applicant-employer regarding correction of the hazards.

(4) Conducting review of incidents resulting in work-related deaths, injuries and illnesses and of complaints regarding health and safety hazards made by committee members or other employees.

(5) Conducting follow-up evaluations of newly implemented health and safety equipment or health and safety procedures to assess their effectiveness.

(6) Establishing a system to allow the committee members to obtain safety-related proposals, reports of hazards or other information directly from persons involved in the operation of the workplace.

(b) A quorum of committee members shall meet at least monthly.

(c) The committees shall additionally:

(1) Develop operating procedures, such as rules or bylaws, prescribing the committees' duties.

(2) Develop and maintain membership lists.

(3) Develop a written agenda for each committee meeting.

(4) Maintain committee meeting attendance lists.

(5) Take and maintain minutes of each committee meeting, which the applicant-employer shall review. Copies of minutes shall be posted or made available for all employees and shall be sent to each committee member.

(6) Ensure that the reports, evaluations and proposals of the committees become part of the minutes of the meeting which shall include:

(i) Inspection reports.

(ii) Reports on specific hazards and corrective measures taken.

(iii) Reports on workplace injuries or illnesses.

(iv) Management responses to committee reports.

(7) Make decisions by majority vote.

§ 129.1006. Committee member training

(a) The applicant-employer shall, itself or through its insurer, provide adequate, annual training programs for each committee member listed in the application.

(b) Annually required committee member training shall at a minimum address:

(1) Hazard detection and inspection.

(2) Accident and illness prevention and investigation (including substance abuse awareness and prevention training), safety committee structure and operation.

(3) Other health and safety concerns specific to the business of the applicant-employer.

(c) Prior to submitting an application to the Bureau and annually thereafter, all committee members shall receive training in the topics listed in subsection (b) from individuals who meet Bureau requirements for accident and illness prevention services providers as defined in Subchapter E (relating to accident and illness prevention services providers requirements) or who have been recognized by the Bureau as qualified trainers.

(d) Applicant-employers are responsible for providing verification of trainer qualifications to the Bureau and supplying, as necessary, documentation supporting individual trainer qualifications.

(e) The applicant-employer shall maintain written records of safety committee training including:

(1) The names of committee members trained.

(2) The dates of training.

(3) The training time period.

(4) The training methodology.

(5) The names and credentials of personnel conducting the training.

(6) The names of training organizations sponsoring training, if applicable.

(7) The training location.

(8) The training topics.

§ 129.1007. Certification

(a) If the Bureau determines that the applicant-employer's committees meets the requirements, it will send a letter of certification approval to the applicant-employer. The Bureau will grant certification approval to an applicant-employer who, by signing the acknowledgements and agreements page of the application, agrees to continue to operate the workplace safety committee according to all requirements upon which initial certification is based. The employer may not disband committees except for valid business reasons.

(b) The insured applicant-employer shall submit a copy of the letter of certification approval to its insurer to receive an initial 5% reduction of its workers' compensation premium. The reduction will be effective upon the commencement of the policy renewal period next following the date of Bureau

certification. An applicant-employer who is a member of a group self-insurance fund established to grant a 5% reduction in annual member contributions, shall submit a copy of the letter of certification to its group self-insurance fund administrator to receive the initial 5% contribution reduction. The reduction will be effective at the commencement of the next group self-insurance fund year following certification.

(c) The Bureau will notify the Pennsylvania Compensation Rating Bureau of approved insured applicant-employers.

(d) If an application is disapproved, the applicant-employer will receive written notification listing specific reasons for disapproval. The applicant-employer may resubmit a corrected application for reconsideration prior to the renewal of its workers' compensation policy, self-insurance renewal year or group self-insurance fund year. The applicant-employer may challenge the disapproval determination under Subchapter G (relating to hearings).

§ 129.1008. Certification renewal affidavit

(a) After initial certification, the applicant-employer may, using form LIBC-372R, Certification Renewal Affidavit of Workplace Safety Committee, apply to the Bureau for renewal of its initial safety committee certification. Affidavits will be generated by the Bureau and provided to eligible applicant-employers for submission. Affidavits shall be submitted to the Bureau between 90 and 15 calendar days prior to the annual renewal of a workers' compensation policy, self-insurance renewal year or group self-insurance fund year. Certification may be renewed for a total of 4 remaining years after the initial certification.

(b) If an applicant-employer has established additional safety committees which have not previously been certified, an Application for Certification of Workplace Safety Committee shall be completed and approved by the Bureau before certification renewal may be granted. Certification renewal approval is granted to an applicant-employer who, by signing the acknowledgements and agreements page of the affidavit, attests that the certified workplace safety committee has continued to operate according to the requirements upon which initial certification approval was based. Employers will not disband committees except for valid business reasons.

(c) If the Bureau determines that the applicant-employer has met certification renewal requirements, it will send a letter of certification renewal approval to the applicant-employer.

(d) An insured applicant-employer shall submit a copy of the letter of certification renewal to its insurer to receive a 5% premium reduction of its workers' compensation insurance premium at the next renewal premium period following the date of Bureau certification renewal. An applicant-employer who is a member of a group self-insurance fund established to grant a 5% reduction in annual member contributions, shall submit a copy of the letter of certification renewal approval to its group self-insurance fund administrator to receive the renewal 5% contribution reduction. The reduction will be effective at the commencement of the next group self-insurance fund year following certification renewal.

(e) The Bureau will notify the Pennsylvania Compensation Rating Bureau of all approved insured applicant-employers.

(f) If a renewal affidavit is disapproved, the Bureau will notify the applicant-employer of the specific reasons for disapproval. The applicant-employer may resubmit a corrected renewal affidavit for reconsideration prior to the renewal of its workers' compensation policy, self-insurance renewal year or group self-insurance fund year. The applicant-employer may challenge the disapproval under Subchapter G (relating to hearings).

§ 129.1009. Information verification

The Bureau may verify the information submitted by application or affidavit including pertinent supporting documentation.

§ 129.1010. Recordkeeping requirements

Copies of the required documents of the functioning committee as defined in §§ 129.1005(c) and 129.1006(e) (relating to committee responsibilities; and committee member training) shall be retained by the applicant-employer for 5 years.

§ 129.1011. Contesting final determinations

An applicant-employer may contest a final application or affidavit determination under Subchapter G (relating to hearings).

SUBCHAPTER G. HEARINGS

§ 129.1301. Purpose

This subchapter sets forth the process to be followed for hearings related to appeals of final determinations of inadequate as they pertain to accident and illness prevention services and programs, final determinations of approved or disapproved as they pertain to a workplace safety committee initial application or renewal affidavit, denials of recognition as an accident and illness prevention service provider or denials of credential recognition.

§ 129.1302. Request for hearing

(a) A party contesting a final determination shall file an original and two copies of a written request for a hearing to the Director within 30 calendar days of the date of the determination. The hearing request shall be made to the Bureau at the address listed on the determination.

(b) A proof of service indicating the date and form of service of the written request for a hearing shall be provided to the Bureau at the time the request for hearing is filed.

§ 129.1303. Hearing process

(a) The Director will assign requests for hearings to an impartial hearing officer who will schedule a de novo hearing. The hearing officer will provide notice to parties of the hearing date, time and place.

(b) The hearing will be conducted in a manner to provide the parties with an opportunity to be heard. The hearing officer will not be bound by strict rules of evidence.

(c) Testimony will be recorded and a full record kept of the proceeding.

(d) Following the close of the record, the hearing officer will issue a written final decision and order.

(e) Any party to the hearing aggrieved by a decision rendered under subsection (d) may, within 30 days, appeal the decision to the Commonwealth Court. The hearing officer's determination will include a notification to the parties of their appeal rights.

(f) Subsections (a) — (e) supplement 1 Pa. Code Part II (relating to the General Rules of Administrative Practice and Procedure).

(g) If, after all appeals have been exhausted, the group self-insurance fund or individual self-insured employer is subject to a final determination that its accident and illness prevention program is inadequate, the group self-insurance fund or individual self-insured employer's certificate to self-insure its obligations under the act shall be void. The group self-insurance fund or individual self-insured employer's failure to properly insure its obligations under the act, through an insurer licensed to provide that coverage in this Commonwealth, within 15 days of the final determination may result in criminal liability under section 305 of the act (77 P. S. § 501).

(h) If, after all appeals have been exhausted, the insurer is subject to a final determination that its accident and illness prevention program is inadequate, the Bureau will notify the Commissioner that the insurer has failed to comply with section 1001(a) of the act (77 P. S. § 1038.1(a)). In that notification, the Bureau may recommend that the insurer's license to write that insurance in this Commonwealth be revoked.

SUBCHAPTER H. ORDER TO SHOW CAUSE/PENALTIES

§ 129.1601. Purpose

This subchapter sets forth the process that the Department may institute to determine whether there has been a violation of the act or related regulations.

§ 129.1602. Order to show cause/penalties

Whenever the Department has information, through its own investigation or through complaint by any party, upon which it believes that an insurer, individual self-insured employer or group self-insurance fund has failed to establish, maintain or provide accident and illness prevention programs or services, using qualified personnel, and to provide proof of those programs or services required under the act, or upon which it believes that an applicant-employer has misrepresented that it has established or maintained a certified workplace safety committee according to Department criteria, the Department may serve upon the insurer, individual self-insured employer or group self-insurance fund, or applicant-employer an order to show cause why the respondent should not be found in violation of Chapter 7E of the act (77 P. S. §§ 1038.1 and 1038.2) or related regulations and civil penalties assessed. The order to show cause will set forth the particulars of the alleged violation.

(1) An answer to the order to show cause shall be filed no later than 20 days following the date that the order to show cause is served on the respondent.

(2) The Director of the Bureau will assign the order to show cause to an impartial hearing officer who will schedule a hearing. The hearing officer will provide notice to the parties of the hearing date, time and place.

(3) The hearing will be conducted in a manner as to provide the parties with an opportunity to be heard and, when applicable, will be conducted under 1 Pa. Code Part II (relating to General Rules of Administrative Practice and Procedure). The hearing officer will not be bound by strict rules of evidence.

(4) Testimony will be recorded and a full record kept of the proceeding.

(5) If the respondent fails to answer or fails to appear in person or by counsel at the scheduled hearing without adequate excuse, the hearing officer will decide the matter on the basis of the order to show cause and evidence presented.

(6) In a proceeding under this section, the Department has the burden to demonstrate, upon a preponderance of the evidence, that the respondent has failed to comply with the act or related regulations.

(7) This section supersedes 1 Pa. Code §§ 35.14 and 35.37 (relating to orders to show cause; and answers to orders to show cause).

TITLE 34. LABOR AND INDUSTRY

PART VIII. BUREAU OF WORKERS' COMPENSATION

CHAPTER 131. SPECIAL RULES OF ADMINISTRATIVE PRACTICE AND PROCEDURE BEFORE WORKERS' COMPENSATION JUDGES

SUBCHAPTER A. GENERAL PROVISIONS

§ 131.1. Purpose

(a) The purpose of this chapter is to promote, consistent with fairness and due process, the orderly and expeditious determination of proceedings before judges under the act and the Disease Law to implement the remedial intent of the act and the Disease Law.

(b) Subsection (a) supersedes 1 Pa. Code § 31.2 (relating to liberal construction).

§ 131.2. Scope

(a) This chapter applies to proceedings before judges under the act and the Disease Law.

(b) Subsection (a) supersedes 1 Pa. Code § 31.1 (relating to scope of part).

§ 131.3. Waiver and modification of rules

(a) The judge may, for good cause, waive or modify a provision of this chapter, except as otherwise provided in §§ 131.59b(a) and 131.202 (relating to mandatory mediation; and first hearing information and stay), upon motion of a party, agreement of all parties or upon the judge's own motion.

(b) Subsection (a) supersedes 1 Pa. Code §§ 33.61, 35.18, 35.54 and 35.55 and also supersedes 1 Pa. Code Chapter 35, Subchapter D (relating to motions).

§ 131.4. Applicability of General Rules of Administrative Practice and Procedure

(a) This chapter is intended to supersede 1 Pa. Code Part II (relating to General Rules of Administrative Practice and Procedure). The General Rules of Administrative Practice and Procedure are not applicable to activities of and proceedings before judges.

(b) Subsection (a) supersedes 1 Pa. Code § 31.4 (relating to information and special instructions).

§ 131.5. Definitions

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

Act — The Workers' Compensation Act (77 P. S. §§ 1 — 1041.4 and 2501 — 2708).

Additional defendant — An insurance carrier, the Commonwealth or an employer, other than the insurance carrier or employer against which the original petition was filed, joined under this chapter, not including the Uninsured Employers Guaranty Fund.

Adjudicating judge — A judge assigned to hold hearings and issue decisions relating to a petition or petitions.

Board — The Workers' Compensation Appeal Board.

Challenge proceeding — A proceeding governed by § 131.50a (relating to employee request for special supersedeas hearing under section 413(c) and (d) of the act).

Claim petition — A petition filed with the Department under section 410 of the act (77 P. S. § 751).

Claimant — An individual who files a petition for, or otherwise receives, benefits under the act or the Disease Law.

Defendant — An employer, insurance carrier and the Commonwealth, unless specifically designated individually, and the Uninsured Employers Guaranty Fund, except for purposes of joinder, penalties or assessment of counsel fees under section 440 of the act (77 P. S. § 996).

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

Department record — Official copies of documents received by the Department, on forms prescribed by the Department, if forms prescribed by the Department are available, or official copies of documents received by the Department on forms prepared by a party if forms prescribed by the Department are not available, which record transactions between the parties and which are determined by the judge to pertain to the case.

Director of Adjudication — The individual specified in section 1402 of the act (77 P. S. § 2502).

Disease Law — The Pennsylvania Occupational Disease Act (77 P. S. §§ 1201 — 1603).

Insurer — A workers' compensation insurance carrier or self-insured employer, as applicable.

Judge — A workers' compensation judge assigned by the Office of Adjudication as provided in sections 401 and 401.1 of the act (77 P. S. §§ 701 and 710) or assigned by the Office of Adjudication to determine a petition filed under the act or the Disease Law.

Judge manager — A workers' compensation judge with management responsibilities appointed under the Civil Service Act (71 P. S. §§ 741.1 — 741.1005).

Mandatory mediation — A mediation conducted by a mediating judge under § 131.59b (relating to mandatory mediation).

Mediating judge — A judge assigned to mediate petitions in accordance with sections 401 and 401.1 of the act and this chapter.

Mediation — A conference conducted by a judge, having as its purpose an attempt to reconcile any or all disputes under the act or this chapter existing between contending parties. Mediation can be either mandatory or voluntary.

Office of Adjudication — The Office of the Department created under section 1401(a) of the act (77 P. S. § 2501 (a)).

Party — A claimant, defendant, employer, insurance carrier, additional defendant, health care provider and, if relevant, the Commonwealth and the Uninsured Employers Guaranty Fund. An act required or authorized by this chapter, to be done by or to a party, may be done by or to that party's counsel of record.

Penalty proceeding — A proceeding governed by section 435(d) of the act (77 P. S. § 991(d)).

Records of work environment — Records and documents relating to work place health, safety, hazards and exposure, including records or documents which may be obtained under the Worker and Community Right-to-Know Act (35 P. S. §§ 7301 — 7320) and 29 CFR 1901.1 — 1928.1027 (relating to Occupational Safety and Health Administration, Department of Labor).

Resolution hearing — A procedure established by the Office of Adjudication with the sole purpose of providing a venue to present a compromise and release to a judge in an expedited fashion.

Statement previously made — A written statement signed or otherwise adopted or approved by the persons making it, or a stenographic, mechanical, electrical, computer-generated or other recording, or transcription thereof, which is a substantially verbatim recital of an oral statement by the person making it and contemporaneously recorded. The term does not include statements made by parties which are protected by the attorney-client privilege or which are protected as the work product of counsel.

Supersedeas — A temporary stay affecting a workers' compensation case.

UEGF — Uninsured Employers Guaranty Fund — The special fund established under Article XVI of the act (77 P. S. §§ 2701 — 2708).

UEGF claim petition — A petition filed with the Department under section 1604 of the act (77 P. S. § 2704).

Voluntary mediation — A mediation conducted by a judge under § 131.59a (relating to voluntary mediation) upon the agreement of the contending parties and the judge.

Writing — Includes electronic communications in a format as prescribed by the Department.

(b) Subsection (a) supersedes 1 Pa. Code §§ 31.3 and 33.33 (relating to definitions; and effect of service upon an attorney).

SUBCHAPTER B. TIME

§ 131.11. Filing, service and proof of service

(a) Whenever filing is required by this chapter, it is deemed complete upon one of the following:

(1) Delivery in person.

(2) If by electronic submission, upon receipt at the electronic address and in a format as prescribed by the Department and published in the *Pennsylvania Bulletin* or the Department's web site located at www.dli.state.pa.us.

(3) If by mail, upon deposit in the United States mail, properly addressed, postage or charges prepaid, as evidenced by one of the following:

(i) United States Postal Service postmark.

(ii) United States Postal Service Certificate of Mailing (USPS Form 3817 or other similar United States Postal Service form from which the date of deposit can be verified), enclosed with the filing or submitted separately to the Department.

(4) A filing may be delivered by a common carrier of property which is subject to the authority of the Pennsylvania Public Utility Commission or the United States National Surface Transportation Board. The date of filing is the date the document was delivered to the common carrier, as established by a document or other record prepared by the common carrier in the normal course of business. If the date of delivery to the common carrier cannot be determined by the documents in the record, the date of filing will be the date of its receipt by the Department.

(b) Whenever service is required by this chapter, it is deemed complete upon one of the following:

(1) Delivery in person.

(2) If by electronic submission, upon receipt and in a format as prescribed by the Department and published in the *Pennsylvania Bulletin* or the Department's web site located at www.dli.state.pa.us.

(3) Except as provided in § 131.81(b) (relating to subpoenas), if by mail, upon deposit in the United States Mail properly addressed, postage or charges prepaid and accompanied by proof of service.

(c) Any notice or other written communication required to be served upon or furnished to a party shall also be served upon or furnished to the party's attorney in the same manner as it is served upon the party.

(d) Whenever a proof of service is required by this chapter, the proof of service must contain the following:

(1) A statement of the date of service.

(2) The names of the judge and others served.

(3) The mailing address, the applicable zip code and the manner of service on the judge and others served, and, if applicable, the electronic address to which service was made.

(e) Unless otherwise specifically provided in this chapter, whenever the filing or service is required to be made upon the Department, it shall be made to an address as may be published in the *Pennsylvania Bulletin* and on the Department's web site located at www.dli.state.pa.us. Electronic filing and service on the Department shall be at the electronic address and in a format as prescribed by the Department and published in the *Pennsylvania Bulletin* and on the Department's web site located at www.dli.state.pa.us.

(f) Subsections (a) — (e) supersede 1 Pa. Code §§ 31.5, 31.11, 31.13, 31.14, 31.26, 33.32 and 33.34 — 33.36.

§ 131.12. Modification of time

(a) Except for answers to petitions as set forth in § 131.33 (relating to answers except answers to petitions for joinder and challenge proceedings), the time fixed or the period of time prescribed in this chapter may, in the exercise of sound discretion and for good cause, be shortened or extended by the judge upon the judge's motion or at the request of a party.

(b) Modifications of time, other than continuances or postponements of hearings, will be governed by the following:

(1) Requests for extensions of time shall be filed at least 3 days before the time specified or as shortened or extended. Requests made within 3 days prior to the time specified or as shortened or extended may be considered if the judge is satisfied that the circumstances relating to the request occurred within those 3 days. After the expiration of the time specified, the act may be permitted to be done if reasonable grounds are shown for the failure to act within the time specified or as previously shortened or extended.

(2) Requests for extensions of time shall be made in writing and state the facts upon which the request rests. During the course of a hearing, the request may be made by oral motion to the judge.

(3) Requests for extensions of time, except those made orally at a hearing, shall be filed with the judge, served upon all parties, and a proof of service of same shall be filed with the judge.

(c) Subsections (a) and (b) supersede 1 Pa. Code §§ 31.6, 31.11, 31.15 and 35.18.

§ 131.13. Continuances or postponements of hearings

(a) It is the intent of this chapter to discourage repeated continuances or postponements of hearings.

(b) Parties shall make every effort to avoid continuances or postponements by the prompt scheduling and submission of expert and medical testimony and by the prompt presentation of lay testimony.

(c) A continuance or postponement may be granted as set forth in this chapter for good cause shown at the discretion of the judge, if the continuance or postponement is consistent with this chapter and its purpose of providing an orderly and expeditious determination of proceedings before judges.

(d) Requests for a continuance or postponement must be:

(1) Made in writing or at a hearing. If not made in writing or at a hearing, confirmed in writing as required by this subsection and served as required by subsection (h).

(2) Made not later than 10 calendar days prior to the hearing date, except as set forth in subsection (f).

(e) Prior to the request for a continuance or a postponement, the party requesting the continuance or postponement shall ascertain the position of all counsel of record and unrepresented parties in the case relating to the continuance or postponement and shall advise the judge of the foregoing at the time of the request.

(f) A request for a continuance or postponement made within 10 calendar days prior to the hearing date will not be considered unless the judge is satisfied that circumstances relating to the requested continuance or postponement occurred within 10 calendar days of the hearing date.

(g) Requests for a continuance or postponement or written confirmation of the continuance or postponement must contain at least the following information:

(1) The identity of the requesting party.

(2) A detailed statement of the position of all counsel of record and unrepresented parties on the request for a continuance or postponement or an explanation of why counsel of record or unrepresented parties could not be contacted.

(3) A detailed statement of the reasons why the continuance or postponement is requested and the date on which the need to request a continuance or postponement arose.

(4) A summary of prior continuances or postponements in the case, at whose request the continuances or postponements were granted and the position of other parties in each continuance or postponement.

(h) A party requesting or confirming in writing a request for a continuance or a postponement other than a request made at a hearing shall serve a copy of the request or the confirmation upon all counsel of record, unrepresented parties and the judge. Counsel requesting or confirming in writing a request for a continuance or a postponement shall serve a copy of the request or confirmation on counsel's client.

(i) Anyone requesting a continuance or postponement shall concurrently with the service of the request or the confirmation file a proof of service with the judge.

(j) In ruling on requests for a continuance or postponement, the judge may consider one or more of the following, giving consideration to subsection (a):

(1) The positions of the various parties relating to the request for a continuance or postponement.

(2) The number of prior continuances or postponements or denials of continuances or postponements and at whose request they were granted or denied.

(3) Whether the requested continuance or postponement will work an undue hardship on a party.

(4) The unavailability of the parties, witnesses or counsel.

(5) The illness or death of the parties or counsel or members of their immediate families.

(6) The desirability of unrepresented parties obtaining counsel.

(7) The necessity to replace the services of an expert witness who becomes unavailable.

(8) Another reason deemed by the judge to be for good cause shown and consistent with this chapter and the purposes of the act and the Disease Law.

(k) A scheduling conflict in another tribunal may be considered but may or may not be determinative.

(l) If a continuance or a postponement is granted, the judge may impose conditions and direct action by the parties which the judge deems reasonable under the circumstances.

(m) In addition to the conditions and actions referred to in subsection (l), the judge may:

(1) Determine why the proceeding should not be dismissed for lack of prosecution or grant the relief sought without the receipt of further evidence or testimony upon the making of appropriate findings of fact.

(2) Schedule a hearing to determine whether to impose penalties under section 435(d) of the act (77 P. S. § 991(d)) and issue an appropriate written order.

(3) Issue a written order modifying in whole or in part a supersedeas order or denial previously entered or modifying an order previously entered upon a showing of compliance with the directions of the judge.

(4) Issue a written order at the end of the case, in the case of a claim petition, with appropriate findings of fact, directing that interest be disallowed. The judge may limit the disallowance of interest to a specified period on good cause shown.

(5) Issue a written order with appropriate findings of fact closing the record and deciding a case if a party has unreasonably delayed the proceeding.

(n) Subsections (a) — (m) supersede 1 Pa. Code §§ 31.15, 33.33 and 35.102 (relating to extensions of time; effect of service upon an attorney; and hearing calendar).

§ 131.14. [Reserved]

§ 131.15. Computation of time

(a) Except as otherwise provided by law, in computing a period of time prescribed or allowed by this chapter, the day of the act, event or default after which the designated period of times begins to run may not be included. The last day of the period so computed shall be included, unless it is Saturday, Sunday or a legal holiday in this Commonwealth, in which event the period shall run until the end of the next day which is neither a Saturday, Sunday nor a legal holiday. A part-day holiday shall be considered as other days and not as a legal holiday. Intermediate Saturdays, Sundays and legal holidays shall be included in the computation.

(b) Subsection (a) supersedes 1 Pa. Code § 31.12 (relating to computation of time).

SUBCHAPTER C. FORMAL PROCEEDINGS

GENERAL

§ 131.21. Identifying number

(a) Pleadings, documents and other submittals filed in a proceeding shall be identified by an identifying number assigned by the Department.

(b) Subsection (a) supersedes 1 Pa. Code §§ 31.5, 33.1 and 33.51 (relating to communications and filings generally; title; and docket).

§ 131.22. Transfer of cases or petitions on agreement of all parties

(a) If the transfer of the case is agreed to by the Office of Adjudication, the parties and the judge, the Office of Adjudication will promptly reassign the case or petition. Notice of reassignment will be given to all parties.

(b) Transfer or reassignment under subsection (a) will take place prior to the date of the first hearing unless circumstances dictate otherwise.

§ 131.23. [Reserved]

§ 131.24. Recusal of judge

(a) The judge may recuse himself on the judge's own motion.

(b) A party may file a motion for recusal, which shall be addressed to the judge to whom the proceeding has been assigned. The judge will conduct an evidentiary hearing and issue a decision within 15 days

following receipt of the evidentiary hearing transcript and post-hearing submissions of the parties. The decision will be interlocutory, unless the judge certifies the record for immediate appeal to the Board.

(c) Subsections (a) and (b) supersede 1 Pa. Code §§ 35.54, 35.55, 35.186, 35.190 and 35.225 and also supersede 1 Pa. Code Chapter 35, Subchapter D.

§ 131.25. – 131.29 [Reserved]

§ 131.30. Consolidation

(a) Where proceedings involve a common question of law or fact, the judge may consolidate the proceedings for hearing on all matters in issue, and may make any appropriate orders concerning the conduct of the proceedings to avoid any unnecessary costs or delay.

(b) Subsection (a) supersedes 1 Pa. Code § 35.45 (relating to consolidation).

PLEADINGS

§ 131.31. Form of pleadings

(a) All proceedings, except challenges under sections 413(c) and 413(d) of the act (77 P. S. §§ 774.2 and 774.3), shall be initiated by petition.

(b) Subsection (a) supersedes 1 Pa. Code §§ 33.1 — 33.4, 33.11, 33.12 and 35.17.

§ 131.32. Petitions except petitions for joinder and challenge proceedings

(a) Petitions shall be in the form prescribed by the Department.

(b) Any petition, filed in accordance with this chapter, shall be filed with the Department as prescribed by the form. If there is no applicable Department petition form available, an original of the petition shall be filed with the Department. The Department will serve a notice of assignment specifying the judge to whom the petition has been assigned. The notice will be served on the parties named in the petition.

(c) Concurrently with filing the petition with the Department, the moving party shall serve a copy of the petition on all other parties, including the insurance carrier, if the insurance carrier is known, and on the attorneys of all other parties, if the attorneys are known.

(d) The material facts on which a cause of action or defense is based shall be stated in a concise and summary form.

(e) Subsections (a) — (d) supersede 1 Pa. Code §§ 31.26, 33.15, 33.21 — 33.23, 33.31, 33.32, 33.37, 35.1, 35.2, 35.5 — 35.7, 35.9 — 35.11, 35.14, 35.17 — 35.20, 35.23, 35.24 and 35.27 — 35.32.

§ 131.33. Answers except answers to petitions for joinder and challenge proceedings

(a) Answers to claim petitions shall be filed in accordance with section 416 of the act (77 P. S. § 821) within 20 days after the date of assignment to the judge. Except petitions for joinder under § 131.36 (relating to joinder), and challenge proceedings which require no answer, answers to all other petitions may be filed within 20 days after the date of assignment to the judge.

(b) Any answer filed in accordance with this chapter shall be filed with the Department as prescribed on the answer form. If there is no applicable Department answer form available, an original of the answer shall be filed with the Department.

(c) Concurrently with filing the answer, the responding party shall serve a copy of the answer on unrepresented parties and on counsel of record.

(d) An answer shall admit or deny each averment of fact in the petition or any part of the averment to which it is responsive. A party denying only a part of the averment shall specify so much of it as is admitted and shall deny the remainder. Where applicable, admissions and denials in an answer shall refer to the specific paragraph in which the averment admitted or denied is set forth.

(e) Subsections (a) — (d) supersede 1 Pa. Code §§ 33.15, 33.37, 35.35 — 35.41, 35.54, 35.55 and 35.161 and also supersede 1 Pa. Code Chapter 35, Subchapter D (relating to motions).

§ 131.34. Other filings

(a) Unless otherwise specifically provided by this chapter, the party filing or submitting a document to the judge shall serve an original on the judge and shall serve a copy on unrepresented parties and counsel of record.

(b) Subsection (a) supersedes 1 Pa. Code §§ 31.24, 31.25, 33.42, 35.51 and 35.169.

§ 131.35. Amendments to pleadings

(a) A party has the right to amend a pleading at any time in a proceeding before a judge, unless the judge determines that another party has established prejudice as a result of the amendment.

(b) Subsection (a) supersedes 1 Pa. Code §§ 33.41, 33.42, 35.40 and 35.48 — 35.51.

§ 131.36. Joinder

(a) A party desiring to join another defendant to assert a claim relevant to the pending petition may do so as a matter of right by filing a petition for joinder.

(b) A petition for joinder shall set forth the identity of employers and insurance carriers sought to be joined and the reasons for joining a particular employer or insurance carrier as well as the specific facts and the legal basis for the joinder.

(c) The petition for joinder shall have attached to it copies of petitions and answers previously filed and a list of the dates and locations of all prior hearings held and depositions taken.

(d) The petition for joinder form shall be filed with the Department no later than 20 days after the first hearing at which evidence is received regarding the reason for which joinder is sought, unless the time is extended by the judge for good cause shown.

(e) An answer to a petition for joinder shall be filed in accordance with section 416 of the act (77 P. S. § 821) within 20 days after the date of assignment by the Department to the judge and may include a motion to strike.

(f) A party filing a petition for joinder or an answer to it shall serve unrepresented parties and counsel of record.

(g) A proof of service shall be attached to the petition for joinder or answer.

(h) After joinder, the original petition shall be deemed amended to assert a claim of the claimant against an additional defendant. The additional defendant is liable to any other party as the judge orders. The additional defendant shall have the same rights and responsibilities under this chapter as the original defendant.

(i) The judge may strike the petition for joinder, and the judge may order the severance or separate hearing of a claim presented therein, or as a result of the joinder.

(j) The judge will issue an order when the motion to strike a petition for joinder is granted.

(k) An order to strike a petition for joinder does not preclude or delay further proceedings before the judge.

(l) Subsections (a) — (k) supersede 1 Pa. Code §§ 31.5, 33.41, 33.42, 35.11, 35.35, 35.40, 35.48 — 35.51, 35.54 and 35.55 and also supersede 1 Pa. Code Chapter 35, Subchapter D (relating to motions).

§ 131.37. — 131.39 [Reserved]

§ 131.40. Frivolous pleadings

If a judge determines after a hearing that a petition or other pleading is frivolous, the judge may, upon the judge's own motion or upon motion by a party, issue a decision dismissing the petition or pleading or issue some other decision within the judge's discretion.

SUPERSEDEAS

§ 131.41. Request for supersedeas or reconsideration of supersedeas

(a) When a petition contains a request for supersedeas, or when a request for supersedeas is made, the judge may rule on the request only after a hearing.

(b) After a hearing, the judge may grant or deny the request for supersedeas in whole or in part. The grant or denial may be for specified or indefinite periods and may be subject to conditions that the judge orders to implement the intent of the act, Disease Law or this chapter. If a supersedeas has been granted or denied in whole or in part, the judge may, upon request or on the judge's own motion, and after hearing, review and modify the grant or denial as warranted.

(c) The decision of a judge on a request for or reconsideration of a supersedeas is an interlocutory order.

(d) Subsections (a) — (c) supersede 1 Pa. Code §§ 35.190 and 35.225 (relating to appeals to agency head from rulings of presiding officers; and interlocutory orders).

§ 131.42. Evidence relating to supersedeas

(a) A party has the right to submit, and the judge may consider, one or more of the following solely in relation to a request for supersedeas.

(1) Testimony of a party or witness.

(2) The report of a physician.

(3) The records of a physician, hospital, clinic or similar entity.

(4) The written statements or reports of another person expected to be called by a party at the hearing of the case.

(5) The report of an organization or governmental body or agency stating the right of the claimant to receive, be denied, have increased or decreased benefits, and the amount of the benefits being paid or payable to the claimant.

(6) Other materials relevant to the request for supersedeas.

(b) Subsection (a) supersedes 1 Pa. Code §§ 35.137, 35.138, 35.161, 35.162 and 35.166.

§ 131.43. Disposition of request for supersedeas

(a) The judge hearing the request for supersedeas will, within 14 days of the hearing, issue a written decision on the request for supersedeas, if granted. Unless a supersedeas is granted by a written order, it will be deemed denied from the date of filing of the request.

(b) Subsection (a) supersedes 1 Pa. Code §§ 35.190 and 35.225 (relating to appeals to agency head from rulings of presiding officers; and interlocutory orders).

§ 131.44 — 131.48 [Reserved]

§ 131.49. Disposition of automatic request for special supersedeas under section 413(a.1) of the act (77 P. S. § 774(1))

(a) The filing of a petition alleging full recovery, accompanied by a physician's affidavit to that effect, which was prepared in connection with an examination of the employee no more than 21 days from the filing of the petition, shall act as an automatic request for supersedeas.

(b) A special supersedeas hearing will be held within 21 days of the assignment of the petition filed under this section.

(c) The judge will approve the request for supersedeas if prima facie evidence of a change in the medical status or of any other fact which would serve to modify or terminate the payment of compensation is submitted at the hearing, unless the employee establishes by a preponderance of the evidence a likelihood of prevailing on the merits of the employee's defense. In making this determination the judge will consider the physician's affidavit alleging full recovery and may consider the following:

(1) The report of the physician.

(2) The testimony of a party or witness.

(3) The records of a physician, hospital or clinic or other similar entity.

(4) The written statements or reports of another person expected to be called by a party at the hearing of the case.

(5) Other evidence relevant to the request for supersedeas.

(d) If the judge to whom the special supersedeas request has been assigned fails to hold a hearing within 21 days of assignment of the request to the judge or fails to issue a written order within 7 days of the hearing of the supersedeas request, the automatic request for supersedeas will be deemed denied. The automatic request for supersedeas will remain denied until the judge issues a written order granting the supersedeas, in whole or in part.

(e) Subsections (a) — (d) supersede 1 Pa. Code §§ 35.137, 35.138, 35.161, 35.162, 35.166, 35.190 and 35.225.

§ 131.50. Return to work - modification or suspension

(a) If an employee returns to work, the insurer may modify or suspend the workers' compensation benefits.

(b) The insurer shall complete and file the form prescribed by the Department. The form shall be provided to the employee, employee's counsel, if known, and the Department within 7 days of the effective date of the suspension or modification of the workers' compensation benefits.

(c) When the insurer previously modified or suspended the employee's benefits under sections 413(c) or 413(d) of the act (77 P. S. §§ 774.2 and 774.3), to effectuate a subsequent modification or suspension of the employee's workers' compensation benefits, the insurer shall file the form specified in subsection (b), indicating the change in the employee's wages and corresponding change in the employee's workers' compensation benefits.

(d) Subsections (a) — (c) supersede 1 Pa. Code § 33.33 (relating to effect of service upon an attorney).

§ 131.50a. Employee request for special supersedeas hearing under section 413(c) and (d) of the act

(a) This section governs the disposition of an employee's request for a special supersedeas hearing made in connection with a challenge to the suspension or modification of workers' compensation benefits under sections 413(c) and 413(d) of the act (77 PS. §§ 774.2 and 774.3).

(b) A special supersedeas hearing will be held within 21 days of the employee's filing of the notice of challenge.

(c) During the course of a challenge proceeding, the issues are limited to determining whether the claimant has stopped working or is earning the wages stated in the Notice of Suspension or Modification under sections 413(c) or 413(d) of the act and the challenge shall be decided only on those issues.

(d) If the employer has filed a separate petition requesting supersedeas, the judge may receive evidence and issue a separate decision on the request for supersedeas if the judge determines the claimant will not be prejudiced by the introduction of evidence on the supersedeas request at the time of the challenge proceeding.

(e) The judge to whom the notice of challenge has been assigned will issue a written order on the challenge within 14 days of the hearing.

(f) If the judge fails to hold a hearing within 21 days or fails to issue a written order approving the suspension or modification of benefits within 14 days of the hearing, the insurer shall reinstate the employee's workers' compensation benefits at the weekly rate the employee received prior to the insurer's suspension or modification of benefits under sections 413(c) or 413(d) of the act.

(g) Subsections (a) — (f) supersede 1 Pa. Code §§ 35.161, 35.162, and 35.190 (relating to form and admissibility of evidence; reception and ruling on orders; and appeals to agency head from rulings of presiding officers).

HEARING PROCEDURE

§ 131.51. Assembly of medical records

The moving party shall assemble medical records to the extent practical prior to the filing of a petition.

§ 131.52. First hearing procedures

(a) The purpose of this chapter is to provide a fair and prompt hearing process, to allow all parties to introduce appropriate evidence and to receive a timely decision from the judge. Where practicable and appropriate, the entire record relating to any petition shall be completed at the initial hearing, recognizing that the hearing process may differ based upon several variables including geographic location, number of parties involved, case volume and availability of experts for testimony.

(b) The hearing process chosen in any specific case, including a determination of whether testimony will be accepted at the initial hearing, is within the discretion of the judge. At or before the initial hearing by written order or on the record, the judge shall establish:

(1) Specific deadlines for the presentation of evidence by the parties.

(2) Dates for future hearings.

(3) Specific date and time for the mediation conference unless, for good cause shown, the judge determines at the first hearing or subsequently that mediation would be futile.

(4) Dates for setting any medical examinations to be scheduled consistent with § 131.53(g) (relating to procedures subsequent to the first hearing).

(c) The moving party, at the first hearing, shall advise the judge and opposing parties of the following:

(1) Allegations and issues of fact and law involved in the moving party's petition.

(2) Proposed amendments to pleadings.

(3) Stipulations of fact.

(4) Names, addresses and method of presentation of witnesses.

(5) Whether the items and information specified in § 131.61(a) (relating to exchange of information), which are intended to be used as evidence or exhibits, have been provided to the responding party at or before the first hearing.

(6) Dates of depositions.

(7) Estimate of hearing time.

(8) Other subjects which may aid in the disposition of the proceeding.

(d) The moving party, at the first hearing, unless otherwise directed by the judge, shall offer and have marked for identification available exhibits of the moving party.

(e) The parties shall identify and provide, if not otherwise electronically available to the judge, all documents required by law to be filed with the Department and which are relevant to issues in dispute with the same injury date and pertaining to the same claim. The judge will place those documents in evidence along with any other documents required to be filed by law with the Department or prior judges and which the judge deems relevant to the proceeding. The judge and the employee may not introduce the First Report of Injury into evidence.

(f) Evidence furnished under this section does not become part of the record, unless otherwise admissible.

(g) Unless otherwise ordered by the judge, the moving party shall present testimony.

(h) Subsections (a) — (g) supersede 1 Pa. Code §§ 35.123, 35.125 — 35.128, 35.155, 35.164 and 35.169.

§ 131.53. Procedures subsequent to the first hearing

(a) Within 45 days after the date of the first hearing actually held, the responding party shall comply with § 131.52(c) (relating to first hearing procedures) and shall submit, in writing, to the judge, with copies to counsel of record and unrepresented parties, the items and information specified in § 131.52(c).

(b) The responding party, in accordance with the directions of the judge, shall offer and have marked for identification the responding party's exhibits.

(c) The judge may issue an order directing the parties to proceed with the litigation in a manner that promotes expeditious resolution and avoids delay.

(d) The parties or the judge may request a conference at any time which may be held in person, by telephone, video, or any other electronic manner as directed by the judge.

(e) A party wishing to present testimony in the form of rebuttal or surrebuttal shall notify the judge in writing within 21 days after conduct of the hearing or deposition at which the testimony to be rebutted or surrebutted has been given.

(f) Following a request to present rebuttal or surrebuttal testimony, the testimony shall be presented at a hearing or deposition provided the testimony shall be taken no later than 45 days after the conclusion of the case of the party presenting the testimony or evidence to be rebutted or surrebutted.

(g) Dates of the medical examinations, if not scheduled prior to the first hearing actually held, shall be scheduled within 45 days after the first hearing actually held.

(h) Subsections (a) — (g) supersede 1 Pa. Code §§ 35.126 — 35.128, 35.137, 35.138 and 35.161 — 35.169.

§ 131.53a. Consolidated hearing procedure

(a) One day trials or other consolidated hearing procedures may be scheduled and conducted pursuant to this chapter to the extent practical. The judge may waive or modify this chapter as may be

appropriate and adopt and direct procedures which are fair and just for a determination of the issues consistent with the act.

(b) Subject to § 131.3(a) (relating to waiver and modification of rules) in cases proceeding under a consolidated hearing procedure:

(1) Upon request, or on the judge's own motion, testimony from a party or witness may be taken by a trial deposition prior to the obligation of a party to conduct medical depositions, or at another appropriate time to clarify the issues.

(2) Upon request, a party shall have the opportunity to testify before the judge at the pretrial or other hearing prior to the obligation of a party to conduct medical depositions, or at another appropriate time to clarify the issues.

(c) Subsections (a) and (b) supersede 1 Pa. Code §§ 35.101 — 35.106, 35.111 — 35.116, 35.121 — 35.128, 35.137, 35.138, 35.155 and 35.161 — 35.169.

§ 131.53b. Bifurcation and motions for disposition of a petition

(a) The judge may, upon request or upon the judge's own motion, consider bifurcation of issues to promote expeditious resolution of cases.

(b) A motion which may result in disposition of a petition may be filed at any time. A response shall be made within a time specified by the judge. The judge will issue an order granting or denying the motion, or will provide reasons why the motion will not be ruled upon, within 30 days of when the response is due. If the motion will not be ruled upon, the judge will articulate in writing or on the record the reasons for not ruling on the motion. Pendency of the motion will not operate as a stay.

(c) Subsections (a) and (b) supersede 1 Pa. Code §§ 35.54, 35.55, 35.177 — 35.180 and 35.225.

§ 131.54. Manner and conduct of hearings

(a) The judge will conduct fair and impartial hearings and maintain order. At the discretion of the judge, the hearings may be conducted by telephone or other electronic means if the parties do not object. Disregard by participants or counsel of record of the rulings of the judge shall be noted on the record, and if the judge deems it appropriate, will be made the subject of a written report to the Director of Adjudication together with recommendations.

(b) If the participants or counsel are guilty of disrespectful, disorderly or contumacious language or conduct in connection with a hearing, the judge may suspend the hearing or take other action as the judge deems appropriate, including the submission of a written report to the Director of Adjudication together with recommendations.

(c) A witness whose identity has not been revealed as provided in this chapter may not be permitted to testify on behalf of the defaulting party unless the testimony is allowed within the judge's discretion.

(d) In addition to subsections (a) — (c), the judge may proceed under § 131.13(m) (relating to continuances or postponements of hearings).

(e) Subsections (a) — (d) supersede 1 Pa. Code §§ 31.21 — 31.23, 31.27 and 31.28 and also supersede 1 Pa. Code Chapter 35, Subchapter E.

§ 131.55. Attorney fees and costs

(a) In all cases, claimant's counsel shall submit a copy of the fee agreement, and a copy of any statement or claim for disbursements, costs and expenses. No agreement or claim for fees or other disbursements, costs or expenses by claimant's counsel shall be valid, and no payments shall be made pursuant thereto, unless approved for payment by the judge before whom the matter is heard or by the Board as provided by law. Except as otherwise approved, no further fee, cost or expense is to be charged.

(b) Under section 440 of the act (77 P. S. § 996), in a disputed claim under the act when the employer or insurer has contested liability in whole or in part, the employee or a dependent, in whose favor the proceeding has been finally decided, will be awarded attorney fees and costs against the employer or insurer, unless the employer or insurer had a reasonable basis for contesting the petition.

(c) Claimant's counsel may file an application for quantum meruit fees at or before the filing of proposed findings of fact, proposed conclusions of law and briefs, and if there are no proposed findings of fact, proposed conclusions of law or briefs requested, at or before the close of the record. The application shall detail the calculation of the fee requested, shall itemize the services rendered and time expended and shall address all factors enumerated in section 440 of the act in support of the application.

(d) Within 15 days after service of the application for quantum meruit fees, an opposing party may file a response to the application detailing the objections to the fee requested.

(e) A decision on the fee award will be made based on the record of the case and, if filed, the application and response. If deemed appropriate by the judge, a hearing may be held and evidence presented.

(f) The application and response will be made exhibits of record and shall be served on unrepresented parties and counsel of record as provided in § 131.34(a) (relating to other filings).

(g) Subsections (a) — (f) supersede 1 Pa. Code §§ 35.1 and 35.2 (relating to applications generally; and contents of applications).

§ 131.56. [Reserved]

§ 131.56a. Withdrawal of appearance

(a) An attorney may withdraw his appearance without leave if another attorney has previously entered or is simultaneously entering an appearance on behalf of the party.

(b) Leave to withdraw an appearance shall be sought by written request to the adjudicating judge. An attorney may not withdraw representation until the adjudicating judge grants the request.

(c) In requesting a withdrawal of appearance, the attorney shall:

(1) Verify whether any party has any objection to the withdrawal request.

(2) Serve notice of the request to withdraw on his own client, all unrepresented parties and counsel of record for all represented parties.

(3) File a proof of service as provided in § 131.11(d) (relating to filing, service and proof of service).

(d) Except for withdrawals of appearance under subsection (a), the adjudicating judge shall, after conducting a hearing on any objection, or on the adjudicating judge's own motion, issue an interlocutory order granting the request unless the adjudicating judge determines that there will be prejudice to the parties or to the proceedings.

(e) Upon withdrawal of appearance, in the event of a fee dispute, the adjudicating judge shall have the authority to determine entitlement to receipt of counsel fees and costs, whether under sections 440 or 442 of the act (77 P. S. §§ 996 and 998), if the fee agreement or petition has been filed before discharge or withdrawal of counsel.

(f) Subsections (a) — (e) supersede 1 Pa. Code §§ 33.32 — 33.37, 35.2, 35.123, 35.124, 35.225 and 35.226.

§ 131.57. Compromise and release agreements

(a) Under section 449 of the act (77 P. S. § 1000.5), upon or after filing a petition, the parties may engage in a compromise and release of any and all liability which is claimed to exist under the act on account of injury or death, subject to approval by the judge after consideration at a hearing.

(b) Proposed compromise and release agreements, including the stipulations of the parties, shall be recorded on a form prescribed by the Department. The parties may attach additional information to the form if circumstances so require.

(c) If another petition is pending before a judge at the time of the agreement of the parties to compromise and release the claim, any party may, in writing, request the judge to schedule a hearing on the proposed compromise and release agreement. The written request will be treated as an amendment of the pending matter to a petition to seek approval of a compromise and release agreement.

(d) The judge will expedite the convening of a hearing on the compromise and release agreement. The judge will circulate a written decision on the proposed compromise and release agreement within 30 days after the hearing. This subsection does not apply if a resolution hearing has been requested in accordance with § 131.60 (relating to resolution hearings).

(e) Subsections (a) — (d) supersede 1 Pa. Code §§ 33.42, 35.40, 35.41, 35.48 — 35.51, 35.101 — 35.106, 35.111 — 35.116, 35.121 — 35.128 and 35.155.

§ 131.58. Informal conferences

(a) Under section 402.1 of the act (77 P. S. § 711.1), the parties upon, or after, filing a petition may agree to participate in an informal conference.

(b) All parties shall agree to participate in the informal conference.

(c) The request for the informal conference shall be recorded on a form prescribed by the Department and filed with the judge to whom the pending petition has been assigned.

(d) If no petition is pending, a petition and corresponding request for the informal conference shall be filed with the Department on a form prescribed by the Department.

(e) The informal conference will be governed by the instructions and procedures specified on the form prescribed by the Department and by section 402.1 of the act.

(f) The request shall be served on all parties and the adjudicating judge.

(g) Subsections (a) — (f) supersede 1 Pa. Code §§ 31.21 — 31.23 and 35.111 — 35.116.

§ 131.59. Mediation

(a) Mediation may be utilized by the parties under this chapter and will not be limited in purpose to achieving a compromise settlement (compromise and release agreement), but may have as a goal the narrowing of issues by means of stipulation for decision by the judge or other amicable resolution.

(b) Subsection (a) supersedes 1 Pa. Code §§ 31.21 — 31.23, 35.111 — 35.116, 35.186 and 35.188.

§ 131.59a. Voluntary mediation

(a) If all parties and the adjudicating judge agree, the adjudicating judge may conduct the voluntary mediation and may subsequently participate in a decision on the merits of the petition or petitions if they are not resolved amicably.

(b) Voluntary mediation activities conducted by judges are confidential.

(c) Subsections (a) and (b) supersede 1 Pa. Code §§ 31.21 — 31.23, 35.111 — 35.116 and 35.188.

§ 131.59b. Mandatory mediation

(a) A mandatory mediation will not be assigned to an adjudicating judge. Petitions not resolved by mediation will proceed before the adjudicating judge as if mediation had not occurred. The mediating judge will not participate in any decision on the merits of the petition or petitions. This subsection cannot be waived or modified, as otherwise provided in § 131.3 (relating to waiver and modification of rules).

(b) Mandatory mediation activities conducted by mediating judges are confidential except that communications, conduct or documents are not confidential if relevant to establish that a party or counsel failed to do one of the following:

(1) Appear for a mediation without prior approval of the mediating judge.

(2) Attend a medication in person or by teleconference, as required by the mediating judge.

(3) Have requisite authority to accept, modify or reject settlement proposals offered at the mediation, whether at the mediation, or within a reasonable period of time after the mediation as established by the mediating judge.

(c) The adjudicating judge shall possess authority to impose sanctions for the failure of the parties to comply with the mediation provisions of sections 401 and 401.1 of the act (77 P. S. §§ 701 and 710) and may consider sections 435(b) and 435(d) of the act (77 P. S. §§ 991(b) and 991(d)), as well as circumstances and sanctions set forth in § 131.13(j) and (m) (relating to continuances or postponement of hearings).

(d) Nothing in this chapter precludes the parties from participating in a voluntary mediation.

(e) Subsections (a) — (d) supersede 1 Pa. Code §§ 31.21 — 31.23, 35.111 — 35.116 and 35.188.

§ 131.60. Resolution hearings

(a) A resolution hearing must be requested in writing.

(b) Counsel for either party, or any unrepresented party, may request a resolution hearing at any time after all parties are prepared to proceed within the time limits prescribed by the act and this rule for resolution hearings.

(c) If a petition is pending before a judge, the request for a resolution hearing must be directed to the assigned judge.

(d) If a petition is not pending before a judge, the request for a resolution hearing must be directed to the Judge Manager for the judge's office serving the county of the claimant's residence. If the claimant resides outside of this Commonwealth, the request must be directed to the Judge Manager for the judge's office most proximate to the claimant's residence. The Judge Manager will assign a judge to conduct the resolution hearing.

(e) The assigned judge's office will schedule the resolution hearing within 14 business days of receiving the request for a resolution hearing.

(f) The Judge Manager may reassign any case from one judge to another to ensure compliance with the resolution hearing requirements of sections 401 and 401.1 of the act (77 P. S. §§ 701 and 710). The Judge Manager will notify both judges of the reassignment.

(g) The judge conducting the resolution hearing will require proof that a petition has been filed with the Department under § 131.11 (relating to filing, service and proof of service), and will make the proof a part of the record. Upon receiving the proof, the judge shall proceed with the hearing and circulate a final decision within 5 business days of the hearing.

(h) The assigned judge need not comply with the procedures in this rule if any party is unable to proceed within the time limits established by the act for resolution hearings.

(i) Subsections (a) — (h) supersede 1 Pa. Code §§ 31.21 — 31.23, 35.48 — 35.51, 35.111— 35.116, 35.185, 35.201 — 35.207 and 35.226.

EXCHANGE OF INFORMATION AND DEPOSITIONS AND DISCOVERY

§ 131.61. Exchange of information

(a) Parties shall exchange all items and information, including medical documents, reports, records, employment records, wage information, affidavits, tapes, films and photographs, lists of witnesses, CD ROMs, diskettes and other digital recordings, to be used in or obtained for the purpose of prosecuting or defending a case, unless the foregoing are otherwise privileged or unavailable, whether or not intended to be used as evidence or exhibits.

(b) The moving party shall provide the items and information referred to in subsection (a) to the responding party prior to the commencement of the first pretrial hearing or hearing actually held. The responding party shall provide the items and information referred to in subsection (a) to the moving party no later than 45 days after the first pretrial hearing or hearing actually held.

(c) A witness whose identity has not been revealed as provided in subsections (a) and (b) may not be permitted to testify on behalf of the defaulting party unless the testimony is allowed within the judge's discretion.

(d) An item or information not exchanged as provided in subsections (a) and (b), which becomes available after the times set forth in subsection (b) shall be exchanged within 15 days after receipt by the party of the item or information.

(e) Statements, documents or other records required to be provided by this chapter, if not provided within the time periods in this chapter or modified under § 131.12 (relating to modification of time), will not be admitted, relied upon or utilized in the proceedings or judge's rulings, as appropriate.

(f) Failure to comply with this section may result in the application of § 131.13(m) (relating to continuances or postponements of hearings).

(g) Subsections (a) — (f) supersede 1 Pa. Code §§ 35.161 and 35.162 (relating to form and admissibility of evidence; and reception and ruling on evidence).

§ 131.62. Oral depositions

(a) The oral deposition of a witness other than a party may be taken and, if taken, may be used only as evidence at hearings. Depositions for discovery may be taken only as provided in § 131.68 (relating to discovery of records).

(b) The oral deposition of a party may be taken only upon approval of the judge and, if taken, may be used only as evidence.

(c) Depositions may be taken by telephone or other electronic means upon agreement of counsel of record and unrepresented parties or, upon motion, as directed by the judge.

(d) Subsections (a) — (c) supersede 1 Pa. Code §§ 35.145 — 35.152.

§ 131.63. Time for taking oral depositions

(a) An oral deposition may be taken at any time subsequent to 30 days after the date of assignment of the petition by the Department.

(b) Oral depositions shall be completed so as not to delay unreasonably the conclusion of the proceedings, and within a time schedule agreed upon by the parties and approved by the judge provided that medical depositions shall be completed as specified in subsections (c) and (e).

(c) The deposition of a medical expert testifying for the moving party shall be taken within 90 days of the date of the first hearing scheduled unless the time is extended or shortened by the judge for good cause shown. The deposition of a medical expert testifying for the responding party shall be taken within 90 days of the date of the deposition of the last medical expert testifying on behalf of the moving party.

(d) A party wishing to present depositions for rebuttal or surrebuttal shall notify the judge in writing within 21 days after the conduct of the hearing or deposition at which the testimony to be rebutted or surrebutted has been given.

(e) Depositions for rebuttal or surrebuttal shall be taken in accordance with § 131.53(e) (relating to procedures subsequent to the first hearing).

(f) If a party fails to abide by the time limits established by this section for submitting evidence, the evidence will not be admitted, relied upon or utilized in the proceedings or the judge's rulings.

(g) Subsections (a) — (f) supersede 1 Pa. Code §§ 35.145 — 35.152, 35.161 and 35.162.

§ 131.64. Notice of oral depositions

(a) The notice of an oral deposition shall be served at least 20 days prior to the date scheduled for the taking of the deposition.

(b) The notice of an oral deposition shall contain the following:

(1) The name or identity, address and occupation of the witness.

(2) The date, time and place of the taking of the oral deposition.

(3) A statement of a relevant reason for the taking of the oral deposition.

(4) The following legend:

Notice to Parties and/or Witness:

You may object to this oral deposition by mailing or delivering a letter listing your objections to (name and address of party scheduling deposition) at least 10 days before (date of deposition).

(c) The notice of an oral deposition shall be served by the party scheduling the deposition upon each witness to be deposed, counsel of record, unrepresented parties and the judge.

(d) Subsections (a) — (c) supersede 1 Pa. Code §§ 33.33 and 35.145 — 35.152.

§ 131.65. Objections to taking of oral depositions

(a) A party or witness may object to the oral deposition by serving, at least 10 days prior to the scheduled date of the oral deposition, a written notice upon the party who has scheduled the oral deposition, counsel of record, unrepresented parties and the judge. The objections shall state the specific reason supporting the objections. The objections shall stay the deposition until it is ordered to be held by the judge.

(b) A party or witness may request a ruling on objections by filing a written request with the judge, which shall be accompanied by a copy of the notice of an oral deposition, any subpoena and the objections lodged as required by subsection (a). The requesting party shall serve a copy of the request for ruling on counsel of record, unrepresented parties and the objecting witnesses.

(c) Upon receipt of a request for ruling, as specified in subsection (b), the judge will, after giving parties and objecting witnesses notice and opportunity to be heard by written submission, in person, or by telephone conference, as the judge may direct, rule on the objections within 5 business days after the parties and objecting witnesses are heard.

(d) Subsections (a) — (c) supersede 1 Pa. Code §§ 35.145 — 35.152.

§ 131.66. Admissibility of oral depositions

(a) Oral depositions taken in accordance with §§ 131.62 — 131.65 or upon waiver of the formal requirements of those sections by agreement of all parties, will be admissible at the time of hearing or by mail if allowed by the judge in the same manner as if the deponent appeared before the judge and testified.

(b) Objections shall be made and the basis for the objections stated at the time of the taking of the depositions. Only objections which are identified in a separate writing, introduced prior to the close of the evidentiary record, as close of the record is specified in §§ 131.101(c) — (e) (relating to briefs, findings of fact and close of record), and stating the specific nature of the objections and the pages where they appear in the deposition or exhibits to which they refer will be preserved for ruling. Objections not so preserved are waived.

(c) Subsections (a) and (b) supersede 1 Pa. Code §§ 35.126, 35.151, 35.161 and 35.162.

§ 131.67. Expenses of taking depositions

(a) If a deposition is to be taken more than 100 miles from where the hearing is or would be scheduled, the judge may order the payment of reasonable expenses of attorneys, not including counsel fees, to attend the deposition.

(b) Subsection (a) supersedes 1 Pa. Code §§ 35.148 and 35.152 (relating to officer before whom deposition is taken; and fees of officers and deponents).

§ 131.68. Discovery of records

(a) A party may schedule and take the deposition of a custodian of records or a person in a similar capacity. A party has the right to inspect and analyze the records listed in this subsection. Title 42 Pa.C.S. §§ 6151 — 6160 (relating to medical records) shall be followed, if applicable. The deposition may be used to locate, authenticate and obtain copies of records which are material and relevant to the proceeding, including:

(1) Employment, earnings or work environment.

(2) Treatment, including vocational and physical rehabilitation.

(3) Mental or physical examination.

(4) Hospitalization.

(5) Testing.

(6) X-rays.

(7) Autopsy.

(8) Tissue slides and samples.

(9) Surveillance.

(b) A party may take the discovery deposition at any time after the assignment of the petition to a judge.

(c) The notice of discovery shall conform to § 131.64(b) (relating to notice of oral depositions) and shall also contain a description of the items to be produced at the deposition.

(d) The service of the notice of discovery shall conform to § 131.64(c).

(e) Objections shall conform to § 131.65 (relating to objections to taking of oral depositions).

(f) A deposition under this section shall be in the form of a written affidavit of the custodian of records as deponent without interrogation. The affidavit shall be in the form, and contain the information specified in § 131.69 (relating to form of deposition affidavit). Title 42 Pa.C.S. §§ 6151 — 6160 shall be followed, if applicable.

(g) The deposition affidavit and the records or items authenticated thereby will be admissible into evidence in the proceeding before the judge in the same manner as if the deponent appeared before the judge and testified to the authenticity of the records or items.

(h) Failure to comply with this section may result in the application of §§ 131.13(m) and 131.61(d) and (e) (relating to continuances or postponements of hearings; and exchange of information).

(i) Subsections (a) — (h) supersede 1 Pa. Code §§ 35.145 — 35.152.

§ 131.69. Form of deposition affidavit

(a) The deposition affidavit required by § 131.68(f) (relating to discovery of records) shall be in the following form:

DEPOSITION AFFIDAVIT OF RECORD CUSTODIAN

I, the undersigned, being duly sworn according to law, depose and say, that I am the duly authorized custodian of records for (name of hospital, doctor, employer, etc.) with the authority to certify said records, and I hereby certify to the following:

(1) The records attached hereto are true and correct copies of the records in my custody, pertaining to (claimant or decedent); and

(2) All records called for in the attached subpoena duces tecum, including this certification, which are in my custody, have been photocopied at my office, in my presence, at my discretion and under my supervision, by (name of copy service, if any); and

(3) All records produced in my presence, unless qualified below, were prepared in the ordinary course of business by authorized persons or personnel at or near the time of the act, condition or event; and

(4) A careful search has been made by me or at my direction for records pertaining to the above identified individual and the records produced pursuant to the attached subpoena duces tecum constitute all of the records of the individual so identified.

(b) Subsection (a) supersedes 1 Pa. Code § 35.149 (relating to oath and reduction to writing).

§ 131.70. Discovery of statements of parties or witnesses

(a) Upon written request, a party is entitled to receive a photostatic copy or other reproduction of a statement previously made concerning the petition or its subject matter by that party, another party or a witness.

(b) Upon written request, a person not a party, is entitled to receive a photostatic copy or other reproduction of a statement concerning the petition or its subject matter previously made by that person.

(c) This section may not apply to statements made by a party to the party's counsel which are protected by the attorney-client privilege or which are protected as the work product of counsel.

(d) Failure to adhere to this section may result in the application of §§ 131.13(m) and 131.61(d) and (e) (relating to continuances or postponements of hearings; and exchange of information), as appropriate.

(e) Subsections (a) — (d) supersede 1 Pa. Code §§ 35.145 — 35.152.

SUBPOENAS

§ 131.81. Subpoenas

(a) Upon written or electronic request of a party or counsel of record in a pending proceeding, the judge will issue a subpoena to compel the attendance of a witness or require the production of books, documents, records, CD ROMs, diskettes, or other digital recordings or other things relevant to the proceeding at a scheduled hearing or deposition within the scope of, and scheduled under, this chapter. The party requesting a subpoena shall complete the subpoena and serve the judge with the original written request and shall serve a copy of the written request on unrepresented parties and counsel of record as provided in § 131.34(a) (relating to other filings).

(b) Subpoenas may not be served until 10 days from the date of issuance unless waived by agreement of the parties.

(c) The party, counsel of record or their respective agents requesting a subpoena shall serve the subpoena that the judge has issued upon the witness or person subpoenaed and upon opposing counsel.

(1) Service shall be made by one of the following:

(i) Personal service under the Pennsylvania Rules of Civil Procedure.

(ii) Any form of mail requiring a return receipt postage prepaid, restricted delivery or as provided in § 131.11(b) (relating to filing, service and proof of service).

(2) The fee for 1 day's attendance and roundtrip mileage shall be tendered upon demand at the time the person is served with the subpoena. If a subpoena is served by mail, a check in the amount of 1 day's attendance and roundtrip mileage shall be enclosed with the subpoena. The fee for 1 day's attendance and roundtrip mileage is as prescribed in 42 Pa.C.S. §§ 5901 — 5988 (relating to depositions and witnesses).

(d) Upon the filing of written objections by a person served with a subpoena or a party, the judge may, after notice to counsel of record and unrepresented parties, promptly quash or limit the scope of a subpoena issued or served.

(e) If the person fails to appear, or has given notice of the intention not to appear, as required by a subpoena duly served, the judge will upon request of a party, communicate to the witness the requirements of the act that the person so appear and advise the person of the enforcement provisions under section 436 of the act (77 P. S. § 992).

(f) Subsections (a) — (e) supersede 1 Pa. Code §§ 35.139 and 35.142 (relating to fees of witnesses; and subpoenas).

STIPULATIONS

§ 131.91. Stipulations of fact

(a) Stipulations of fact may be filed with the judge to whom the case has been assigned.

(b) The judge may issue a decision based on stipulations of fact, if the judge is satisfied that:

(1) The stipulations of fact are fair and equitable to the parties involved.

(2) The claimant understands the stipulations of fact and the effect of the stipulations of fact on future payments of compensation and medical expenses.

(3) The stipulation shall be signed and dated by the claimant, all counsel participating in the agreement and the employer, when unrepresented.

(4) The stipulation states which petitions are being resolved and which petitions are not being resolved.

(5) The stipulation states whether each petition should be withdrawn, granted or dismissed, and whether the parties are requesting an interlocutory or a final order.

(c) Subsections (a) and (b) supersede 1 Pa. Code § 35.155 (relating to presentation and effect of stipulations).

BRIEFS, FINDINGS OF FACT, CLOSE OF RECORD AND ORAL ARGUMENT

§ 131.101. Briefs, findings of fact and close of record

(a) The judge may require the parties to submit proposed findings of fact, conclusions of law and legal briefs or memoranda to the judge for review and consideration.

(b) Submissions referred to in subsection (a) shall be made within the time specified by the judge, but not later than 30 days following the close of the record.

(c) The evidentiary record is closed when the parties have submitted all of their evidence and rested or when the judge has closed the evidentiary record on a party's motion or the judge's own motion. If the judge determines that additional hearings are necessary, or that additional evidence needs to be submitted, or if the judge schedules additional written or oral argument, the evidentiary record may be held open by the judge. When the judge determines that the evidentiary record is closed, the judge will notify the parties that the evidentiary record is closed on the record or in writing.

(d) A party may move to close the evidentiary record and all other parties shall advise the judge within 20 days as to whether the evidentiary record is closed or whether there is additional evidence to be submitted. At the conclusion of the 20-day period, the judge will determine whether the evidentiary record will be closed or will remain open.

(e) A judge may close the evidentiary record on the judge's own motion even if all parties have not rested when the judge determines that the parties have had reasonable opportunity to present their case, provided that reasonable notice of the closing of the evidentiary record has been given to all parties.

(f) All parties shall provide a certification of the contents of the evidentiary record before the judge, including hearing dates, a list of witnesses testifying and a list of offered exhibits. The certification

of the evidentiary record shall be provided to the judge after the close of the evidentiary record and at or before the filing of proposed findings of fact, conclusions of law or brief. The judge will specify the contents of the evidentiary record in the decision.

(g) Proposed findings of fact, proposed conclusions of law, briefs and certification of the evidentiary record not timely filed with the judge may not be considered unless, in advance of the date specified in this section, a request for an extension of time has been made to, and granted by, the judge for good cause shown.

(h) Briefs submitted under this section shall consist of at least the following items separately and distinctly set forth:

(1) A short statement of the questions involved.

(2) A statement of the facts by the moving party or counter-statement of the facts by the responding party.

(3) An argument.

(4) Short conclusions setting forth the precise relief sought.

(5) A proof of service.

(i) Subsections (a) — (h) supersede 1 Pa. Code §§ 35.54, 35.55, 35.131 — 35.133, 35.163, 35.173, 35.191 — 35.193, 35.212, 35.221 and 35.231 — 35.233 and also supersede 1 Pa. Code Chapter 35, Subchapter D.

§ 131.102. Oral argument

(a) The judge, with notice to the parties, may require oral argument at any time before or after the close of the evidentiary record. A party may request oral argument at any time prior to the submission of the parties proposed findings of fact, proposed conclusions of law or brief. If no proposed findings of fact, proposed conclusions of law or brief are filed, a party may request oral argument prior to the close of the evidentiary record.

(b) Subsection (a) supersedes 1 Pa. Code §§ 35.204, 35.214 and 35.221 (relating to oral argument before presiding officer; oral argument on exceptions; and briefs and oral argument in absence of proposed report).

DECISIONS

§ 131.111. Decision of judges

(a) Following the close of the evidentiary record and the hearing of oral argument, if any, as provided in § 131.102(a) (relating to oral argument), the judge will issue a written decision, which will contain findings of fact, conclusions of law and an appropriate order based upon the entire evidentiary record.

(b) The decision of the judge will be a final order, subject to correction or amendment under § 131.112 (relating to correction or amendment of decision) or appeal.

(c) In any petition which may result in the payment of a monetary award subject to 23 Pa.C.S. § 4308.1 (relating to collection of overdue support from monetary awards), a decision will not be issued until

the claimant provides to the judge a written statement signed by the claimant and made subject to 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities), including:

(1) The claimant's full name, mailing address, date of birth and Social Security number.

(2) Whether there is an outstanding child support order against the claimant, and if so, whether payments are current or in arrears.

(3) Written documentation of arrears from the Pennsylvania Child Support Enforcement System web site, or, if no arrears exist, written documentation from the web site indicating no arrears.

(d) Subsections (a) and (c) supersede 1 Pa. Code §§ 35.190, 35.201 — 35.207, 35.225, 35.226 and 35.241.

§ 131.112. Correction or amendment of decision

(a) A decision or an order of a judge may be amended or corrected by the judge subsequent to the service of notice of the decision and order. A typographical or clerical error or obvious omission or error on the part of the judge may be corrected on the judge's motion or on the motion of one or both parties. Other amendments or corrections will be made only upon written agreement of the parties. A request for correction or amendment shall be made within 20 days of the date of service of notice of the decision and order.

(b) The corrected decision and order will specifically set forth the items in the prior decision and order which are being corrected and amended, and will contain the following provision: "In all other respects the prior decision and order in the case are hereby reaffirmed."

(c) Neither the request for correction nor the corrected decision and order will extend the appeal period of the original decision and order as to any part of that decision and order which is not the subject of the request for correction or amendment.

(d) Subsections (a) — (c) supersede 1 Pa. Code §§ 31.13, 31.14, 35.54, 35.55, 35.190 and 35.211 — 35.214 and also supersede 1 Pa. Code Chapter 35, Subchapter D.

PENALTY PROCEEDINGS

§ 131.121. Penalty proceedings initiated by a party

(a) Penalty proceedings may be initiated by a party filing a petition for penalties as provided in § 131.32 (relating to petitions except petitions for joinder and challenge proceedings). Answers shall be filed as provided in § 131.33 (relating to answers except answers to petitions for joinder and challenge proceedings).

(b) Penalty proceedings initiated by a party in a pending proceeding may be initiated by a petition under subsection (a) or by motion on the record in the pending proceeding. If penalties are requested by motion on the record, an answer may be made either orally on the record or as provided in subsection (a).

(c) If, in a pending proceeding where no separate penalty petition has been filed in accordance with subsection (a), it appears to the judge in proceedings before the judge that there has been noncompliance with the act or this chapter, the judge will schedule a hearing for the purpose of determining if noncompliance has occurred unless the hearing is waived by the parties. The hearing will be scheduled either upon motion of a party or on the judge's own motion unless waived.

(d) The judge will give notice of the scheduling of any penalty hearing to all parties and this notice will specify the nature of the penalty proceeding and that the hearing will involve the question of the imposition of penalties under the act or this chapter.

(e) The penalty hearing may be conducted in conjunction with a hearing on the merits in a pending proceeding or at a separate hearing.

(f) At the penalty hearing, the judge will take testimony, receive evidence and hear arguments necessary to create a record sufficient to support, defend or appeal the decision of the judge regarding noncompliance with the act or this chapter and the imposition of penalties.

(g) A party complaining of a violation of the act or this chapter shall have the burden of proving the violation.

(h) The judge, in a separate order prior to a final order or in conjunction with the final decision in the proceeding, will rule on the request for penalties and will determine whether noncompliance with the act or this chapter exists, and, if appropriate, impose penalties.

(i) Subsections (a) — (h) supersede 1 Pa. Code §§ 35.1, 35.2, 35.5 — 35.7, 35.9 — 35.11, 35.14, 35.17 — 35.20, 35.23, 35.24, 35.35 — 35.41, 35.54, 35.55 and 35.251 and also supersede 1 Pa. Code Chapter 35, Subchapter D.

§ 131.122. Other penalty proceedings

(a) Penalty proceedings not conducted under § 131.121 (relating to penalty proceedings initiated by a party) will be conducted in accordance with Chapter 121 (relating to general provisions).

(b) Subsection (a) supersedes 1 Pa. Code §§ 35.14, 35.37 and 35.251 (relating to orders to show cause; answers to orders to show cause; and reports of compliance).

SUBCHAPTER D. PROCEEDINGS INVOLVING THE UEGF

§ 131.201. Petitions

(a) All references to petitions in this subchapter are as defined under § 131.5 (relating to definitions).

(b) Subsection (a) supersedes 1 Pa. Code § 31.3 (relating to definitions).

§ 131.202. First hearing information and stay

(a) At the first hearing on a claim petition where no UEGF claim petition has been filed and there is either no insurer listed on the notice of assignment or the listed insurer files a motion to dismiss for lack of coverage, the judge will inform the claimant on the record of the existence of the UEGF and give the claimant information about the UEGF, as provided by the Office of Adjudication.

(b) If the claimant informs the judge on the record that he may wish to file a UEGF claim petition, the judge will stay the proceeding in the claim petition until 20 days after the assignment of the UEGF claim petition. The stay may not apply to the exchange of information referenced in § 131.61 (relating to exchange of information).

(c) If no UEGF claim petition is filed within 45 days of the first hearing, the claim petition will proceed against the uninsured employer.

(d) If the claimant informs the judge on the record that he does not wish to file a UEGF claim petition, testimony may be taken as directed by the judge.

(e) In the interests of judicial economy and due process to have all parties joined as soon as possible, and in recognition of the uniqueness of the UEGF from other types of workers' compensation litigation, this section cannot be waived or modified as otherwise provided in § 131.3 (relating to waiver and modification of rules).

(f) Subsections (a) — (e) supersede 1 Pa. Code §§ 33.61, 35.18, 35.123 — 35.128, 35.187 and 35.188.

§ 131.203. Hearing procedures

(a) If the UEGF requests live testimony of witnesses before the judge, the judge will schedule such hearings to accommodate the request, unless denied for good cause shown and stated on the record.

(b) Subsection (a) supersedes 1 Pa. Code §§ 35.101 — 35.106, 35.111 — 35.116, 35.121 — 35.128, 35.137, 35.138, 35.155 and 35.161 — 35.169.

§ 131.204. UEGF subpoenas and interrogatories

(a) The judge may issue subpoenas, order testimony or compel the completion of written interrogatories with respect to the alleged uninsured employer's financial history, condition or ability to pay an award.

(b) The judge may compel the attendance of all parties at mediation.

(c) Subsections (a) and (b) supersede 1 Pa. Code §§ 35.111 — 35.116, 35.137 — 35.147, 35.150, 35.161, 35.162, 35.187 and 35.188.

CHAPTER 141. [RESERVED]

CHAPTER 143. [RESERVED]

Statements of Policy

TITLE 34. LABOR AND INDUSTRY

PART VIII. BUREAU OF WORKERS' COMPENSATION

CHAPTER 122. GENERAL PROVISIONS OF ACT 57 OF 1996 – STATEMENT OF POLICY

SUBCHAPTER A. [RESERVED]

§§ 122.1 – 122.11. [Reserved]

SUBCHAPTER B. [RESERVED]

§§ 122.101 – 122.104. [Reserved]

SUBCHAPTER C. [RESERVED]

§§ 122.201 and 122.202. [Reserved]

SUBCHAPTER D. [RESERVED]

§§ 122.301 – 122.303. [Reserved]

SUBCHAPTER E. [RESERVED]

§ 122.401. [Reserved]

SUBCHAPTER F. [RESERVED]

§§ 122.501 and 122.502. [Reserved]

SUBCHAPTER G. COORDINATED CARE ORGANIZATIONS – STATEMENT OF POLICY

§ 122.601. Applicability and purpose

(a) This subchapter provides information to employers, workers' compensation insurers, providers, provider organizations and injured workers concerning how the Department proposes to exercise its authority under the act to certify and monitor CCOs. The information will enable potential applicants for certification to commence the application process. This subchapter is not, and does not purport to be, a regulation. It does not, therefore, have the force of law. Rather, it expresses the present intentions of the Department with respect to implementing the certification program.

(b) This subchapter should be reviewed by persons who undertake to establish, operate and maintain a CCO.

§ 122.602. Definitions

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

Act — The Workers' Compensation Act (77 P. S. §§ 1 — 1031).

Adequate access — A reasonable distance an injured worker must travel to secure primary medical services through a CCO, generally not greater than a 30-minute non-rush hour drive from the worker's home or place of employment, whichever is the more appropriate point.

Bureau — The Bureau of Health Care Financing of the Department.

CCO — Coordinated Care Organization — An organization licensed in this Commonwealth and certified by the Department to provide medical services to an injured worker after it demonstrates that it has met the criteria for certification as a CCO established by section 306(f.2) of the act (77 P. S. § 531.1).

Case management — A collaborative process, system or service which assesses, plans, supports, implements, coordinates, monitors and evaluates options and services to meet an injured workers' health needs through communication and available resources to promote quality cost-effective outcomes, and which deals primarily with the social, personal and economic factors relevant to a worker's injury, but which does not include the actual provision of medical care, treatment or services.

Department — The Department of Health of the Commonwealth.

Injured worker — A worker or employe entitled to or claiming compensation or medical benefits under or covered by the act.

Organization licensed in this Commonwealth — A single entity — that is, a partnership, corporation, and the like — which is authorized to do business in this Commonwealth and which has a clearly identifiable and unified administrative and functional structure as determined by the Department.

Participating coordinated care provider — A provider who is employed by a CCO or a CCO affiliate or who has entered into an agreement or contract with a CCO, and who provides treatment, accommodations, products or health services to injured workers pursuant to that relationship.

Primary medical services — The following services frequently utilized by injured workers:

(i) Inpatient hospital medical surgical services.

(ii) Hospital emergency room or urgent care center services.

(iii) Primary care physician — family practitioner or general internal medicine — services.

(iv) Diagnostic imaging facility services.

(v) Inpatient and outpatient physical therapy and rehabilitation services.

(vi) Rehabilitation medicine specialist services.

(vii) Orthopedic specialist services.

(viii) General surgery specialist services.

(ix) Ophthalmology specialist services.

(x) Chiropractic services.

(xi) Neurological specialist services.

(xii) Mental health professional services.

Single service referral, provider participation and payment agreement — A combined referral form and provider agreement utilized by a CCO to refer an injured worker to a provider who has not entered into a general contract or agreement with the CCO to treat the injured workers referred by the CCO.

§ 122.603. Uncertified CCOs

(a) An individual, partnership, corporation or other entity may not operate or maintain a CCO unless it has been certified as a CCO by the Department.

(b) In determining whether an entity requires certification as a CCO, the Department will consider whether it engages in any of the activities described in or required by §§ 122.609 — 122.613 and 122.615.

(c) The Department will not consider an entity which engages in activity limited to case management to require certification as a CCO if the entity does not hold itself out as or operate as a CCO.

§ 122.604. Application process

(a) An applicant for certification as a CCO shall submit the following to the Bureau:

(1) Two copies of a completed application form, available from the Bureau, Room 1026 Health and Welfare Building, Post Office Box 90, Harrisburg, Pennsylvania 17108-0900.

(2) Two copies of written documentation to supplement its application and establish that it meets the requirements in the act and this subchapter.

(3) A certified check in payment of the application fee as established by regulation.

(b) The Department will consider an application to be incomplete if the submissions fail to conform with subsection (a) or do not reflect a good faith attempt by the applicant to provide a detailed and credible response to each question and include adequate and appropriate documentation when required.

(c) When the Department finds an application to be incomplete, makes a preliminary determination that the documentation submitted is inadequate to demonstrate that the applicant has met the requirements for certification or has questions about or needs clarification of an element of the application, the Department will send a letter to the applicant advising it of the inadequacies and requesting additional information or documentation, as appropriate.

(d) The Department will review complete applications on a first received-first reviewed basis, based upon the date and time each application is date-stamped as having been received by the Bureau. When an incomplete application is made complete through subsequent filings, it will be placed last on the list for reviewing complete applications.

§ 122.605. Certification application fees

(a) The Department will establish a certification application fee by regulation. The regulation will establish the procedures and requirements for paying this fee.

(b) The Department anticipates that the application fee will be approximately $1,500. The Department also anticipates that it will bill persons for the fee if they applied prior to the effective date of the regulation, and that issuance of an initial certificate or a renewal certificate may be conditioned upon payment of the fee.

§ 122.606. Certification periods

A certificate will be valid for 2 years from the date of its issue, unless the certificate is earlier suspended or revoked by the Department for failure of the CCO to meet the provisions of section 306(f.2)(4) of the act (77 P. S. § 531.1(4)) or applicable regulations.

§ 122.607. Recertification

(a) A CCO shall apply for recertification as a CCO no later than 120 days prior to the expiration date of its certification.

(b) The Department will establish a fee to apply for recertification by regulation. The Department anticipates that the fee will be approximately $1,500.

(c) An application for recertification shall include information the Department may require to demonstrate that the CCO has been operating and will continue to operate in accordance with the act and this subchapter.

(d) A CCO applying for recertification shall also include the following in its recertification application:

(1) A detailed report of the status of the completion of its quality assurance work plan, as set forth in the initial application for certification or subsequent application for recertification.

(2) A summary of the results of the injured worker satisfaction surveys.

(3) A summary of changes, and documentation relevant to those changes as required by § 122.608 (relating to contents of an application for certification as a CCO), if the information or documentation which was required for CCO certification under § 122.608 has changed since the most recent application and has not been previously reported to or approved by the Department.

§ 122.608. Contents of an application for certification as a CCO

An application for certification as a CCO 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 or a workers' compensation insurer.

(ii) A list of the owners of the proposed CCO with a 5% or greater ownership interested.

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

(2) An organization chart listing reporting relationships and the positions supporting the operations of the CCO, particularly in the areas of utilization review, quality assurance, case management and communication and provider relations. An addendum to the chart shall describe how increased utilization of CCO services will affect staffing and staffing to injured worker ratios.

(3) A description of the geographic service area by county in which the CCO proposes to operate. The description shall demonstrate how the applicant will comply with § 122.609 (relating to requirements for a CCO's health service delivery system).

(4) A complete list of participating coordinated care providers:

(i) Identifying whether the provider is an employe or affiliate of or has entered into a contract or agreement with the CCO.

(ii) Identifying the geographic area — usually county — in which each provider practices and its specialty.

(iii) Explaining how the CCO's contractual arrangements with providers meet the requirements of § 122.610 (relating to standards for contracts and agreements with providers).

(5) A map of the proposed service area indicating the location of participating coordinated care providers.

(6) A copy of the generic contract the applicant will utilize to contract with workers' compensation insurers and self-insured employers to offer its services and negotiate provider rates of payment.

(7) A copy of literature in draft or final form that the applicant will utilize to market its services to workers' compensation insurers, self-insured employers and injured workers, and a copy of injured worker literature which meets the requirements of § 122.625 (relating to injured worker literature). If final-form literature is not available for submission with the application and the applicant meets the other standards, the Department will conditionally certify the applicant as a CCO if it has provided draft literature, conditioned upon its submission of literature in final form within 60 days of approval. The Department will withdraw the conditional certification if the final-form literature is not submitted to it within the 60 days or if the literature is not satisfactory to the Department.

(8) A description of the manner in which an injured worker initially selecting the CCO shall gain access to treatment by a participating coordinated care provider. This document shall meet the requirements of § 122.609.

(9) A copy of generic form contracts, or letters of agreement, and compliance riders used by the applicant to contract with participating coordinated care providers. These documents shall meet the requirements of § 122.610.

(10) A description of how the applicant's case management and evaluation system meets the requirements of § 122.611(a) (relating to standards for a case management and evaluation system and case communication system), and a copy of the written record required by § 122.611(a)(1).

(11) A description of the applicant's case communication system which demonstrates how the applicant meets the standards of § 122.611(c).

(12) A description of the applicant's utilization review system which demonstrates how the applicant meets the standards of § 122.612 (relating to standards for utilization review), and a copy of the documentation specified in § 122.612(a)(6)(i).

(13) A description of the applicant's quality assurance system which demonstrates how the applicant meets the standards of § 122.613 (relating to standards for quality assurance program), and a copy of the documentation specified in § 122.613(2), (5) and (6).

(14) A description of the applicant's written grievance system which demonstrates how the applicant meets the standards of § 122.615 (relating to injured worker grievance system and provision of alternatives), and a copy of the documentation specified in § 122.615(g).

(15) If the applicant seeks exemption of a provision in section 306(f.2)(2) and (3) of the act (77 P. S. § 531.1(2) and (3)), the specific requirements from which it seeks exemption and the justification for the applicant's inability to meet the requirements.

(16) A description of the injured worker satisfaction survey process the applicant will utilize to survey injured workers who have been treated by the CCO which demonstrates how the applicant meets the standards of § 122.614 (relating to injured worker satisfaction program).

(17) A copy of the proposed single service referral, provider participation and payment agreement, if any, to be utilized by the applicant to coordinate and manage referrals, which demonstrates how the applicant meets the standards of § 122.609(c)(2).

(18) A copy of the policy face sheet or other evidence that the applicant has medical malpractice liability insurance or errors and omissions liability insurance, as appropriate, for the liability risks assumed by the applicant.

(19) A copy of a contract with an independent organization from which the applicant chooses to purchase case management and communication or utilization review services, if it chooses not to provide the services directly through its own employed staff or the staff of an affiliate/subsidiary, which demonstrates how the applicant meets the requirements of § 122.626 (relating to contracts with independent organizations for performance of case management and communication or utilization review services).

§ 122.609. Requirements for a CCO's health service delivery system

(a) An applicant, to be certified or recertified, and a CCO to maintain a CCO certification, shall have the following:

(1) An adequate number and specialty distribution of licensed participating coordinated care providers to provide primary and other medical services to injured workers.

(2) The capacity to provide all primary medical services to injured workers.

(3) The establishment and maintenance of referral capacity to treat other injuries and illnesses.

(4) A system which provides timely delivery of health care services to the injured worker.

(b) To establish that it meets the standards in subsection (a)(1) and (2), an applicant for certification or recertification as a CCO shall present evidence that it employs, owns or has acceptable provider contracts or agreements with a sufficient number and distribution of providers within a reasonably defined service area within which an injured worker shall have adequate access to primary medical services.

(c) To establish that it meets the standards in subsection (a)(3), an applicant for certification or recertification as a CCO shall demonstrate that it has written procedures to do at least one of the following:

(1) Enter into an agreement with the provider to whom the injured worker is to be referred by which the provider agrees to treat the injured workers referred by the CCO. The agreement shall meet the requirements of § 122.610 (relating to standards for contracts and agreements with providers).

(2) Enter into an agreement with the provider to whom the injured worker is to be referred, when a referral becomes necessary, by which the provider agrees to treat the specific injured worker being referred. The agreement which may be referred to as a single service, provider referral, participation and payment agreement, shall be subject to approval by the Department, but because of its limited nature, need meet only the following requirements instead of the requirements of § 122.610. The agreement shall:

(i) Contain identification of the CCO initiating the referral, the injured worker being referred, the referral services requested and the payor source — workers' compensation insurer or self-insured employer.

(ii) Include a provision asserting that by signing the form and submitting a bill to the payor, the provider accepting the referral agrees to limited participation in the CCO for the named injured worker only.

(iii) Include a provision by which the provider to whom the injured worker is to be referred agrees to cooperate with the CCO's case management, utilization review and quality assurance systems as applied to the care provided the named individual injured worker, and agrees to abide by the decisions of these CCO systems.

(iv) Include a provision by which the provider to whom the injured worker is to be referred agrees to accept the fee level negotiated by the CCO as payment in full for services it provides the injured worker which are covered under the act.

(v) Include a provision by which the provider to whom the injured worker is to be referred agrees to provide the CCO and the Department access to the injured worker's medical records.

(vi) Include a provision asserting that the provider to whom the injured worker is to be referred accepts that the injured worker's signature on the referral form constitutes permission to release the injured worker's medical records regarding treatment by that provider to the CCO and the Department.

(d) To establish that it meets the standards for timely delivery of health care services in subsection (a)(4), an applicant for a CCO certification or recertification shall present evidence in the form of written policies and procedures, provider contract or agreement requirements or otherwise, which demonstrates that the CCO health service delivery system will meet and continue to meet the following conditions:

(1) Medically necessary urgent care shall be provided within 24 hours of the request for the care by the injured worker or another person, on the injured worker's behalf, if the injured worker is incapable of making the request.

(2) If referral for specialty care is required, the referral shall occur within 48 hours of the identification of the need for the specialty care and the specialty care shall be provided or arranged for within 96 hours of identification of the need for specialty care.

(3) Nonurgent care shall be provided or arranged for within seven days of the request for the care.

§ 122.610. Standards for contracts and agreements with providers

(a) A contract or agreement between a CCO and a participating coordinated care provider, unless the provider is employed by the CCO or is an affiliate/subsidiary of the CCO, shall contain the following

minimum provisions necessary to enable the CCO to coordinate and manage care in a high quality manner and protect injured workers:

(1) A provision requiring the participating coordinated care provider to accept the CCO reimbursement schedule as payment in full for services covered by the act which are rendered to an injured worker.

(2) A provision prohibiting the participating coordinated care provider from collecting or attempting to collect from an injured worker payment for treatment or service provided by the provider and determined by the CCO not to be medically necessary or in accordance with clinical protocols established by the CCO. The provision shall likewise prohibit the participating coordinated care provider from collecting or attempting to collect from an injured worker a financial penalty imposed upon the provider for failure to abide by the CCO's precertification or other utilization review or case management requirements.

(3) A provision requiring the participating coordinated care provider to abide by the CCO's standards for medical records and to provide medical record access to the CCO and the Department or an external quality review organization approved by the Department and selected by the CCO or the Department to review the quality of care being provided by the CCO.

(4) A provision requiring the participating coordinated care provider to participate in and abide by the decisions of the CCO's quality assurance, utilization review and injured worker grievance systems.

(5) A provision requiring the participating coordinated care provider to abide by the internal rules, regulations and guidelines of the CCO regarding referrals, case management, case communication, data reporting requirements and other matters affecting the internal administration of the CCO's delivery system.

(6) A provision requiring the participating coordinated care provider to promptly report to the CCO a change in its status under the CCO's credentialing requirements, including loss or diminishment of hospital privileges and loss or restriction of license.

(7) A provision requiring the participating coordinated care provider to provide or arrange for the provision of medially necessary services as required by § 122.609 (relating to requirements for a CCO's health service delivery system).

(8) A provision requiring the participating coordinated care provider to accept referrals from the CCO or other participating coordinated care providers within the CCO network, and whenever possible and medically appropriate, to refer injured workers to participating coordinated care providers within the CCO network within the time frames and in accordance with other standards in § 122.609.

(9) A provision setting forth the circumstances under which a participating coordinated care provider may discontinue treatment of or refuse treatment to an injured worker with whom the provider has failed to establish a provider-patient relationship and requiring the referral of the injured worker to another appropriate provider within the time frames in § 122.609(d).

(10) A provision requiring that no change in the provider contract or agreement shall be effective, except for changes required by the Department, without 30 days advance notice and the opportunity to cease participation in the CCO if the changes are unacceptable to the participating coordinated care provider.

(11) A provision requiring the participating coordinated care provider to abide by the CCO's and the Department's confidentiality requirements.

(12) A provision specifying the contract or agreement termination rights and termination notice requirements for both the CCO and the participating coordinated care provider. Both the CCO and the participating coordinated care provider shall have the right to terminate the contract or agreement with no more than 60 days advance notice.

(b) A CCO that delivers services in whole or part through employed providers shall impose upon the employes the same requirements it is required to impose on contracted providers in subsection (a).

(c) An applicant for a CCO certification, which has existing provider contracts, may meet the requirements of subsection (a) through an appropriate provider contract rider, which shall be submitted as part of its application.

(d) Information relating to a CCO's reimbursement rates, which is received by the Department under this section, shall be confidential, except that the Department may use the data, without identification of a particular provider, as part of the Department's efforts to provide statistical reports on the operation of CCOs under the act.

§ 122.611. Standards for a case management and evaluation system and case communication system

(a) A CCO shall establish, operate and maintain a case management and evaluation system which includes continuous monitoring of treatment from onset of the injured worker's injury or illness until the injured worker leaves the care of the CCO, and which meets the following standards. The system shall:

(1) Maintain a written record of staffing of its case management and evaluation system, the professional expertise of the staff and staffing to injured worker ratios.

(2) Be staffed by an adequate number of trained and experienced registered nurses and rehabilitation specialists who are trained and experienced in workers' compensation or disability management and supervised by appropriate clinicians.

(3) Monitor an injured worker's progress through appropriate daily or weekly contact with the injured worker and persons providing health services to the injured worker.

(4) Assist the injured worker, the worker's family and participating coordinated care providers treating the worker to develop appropriate treatment plans and make referrals within the CCO network.

(5) Work with participating coordinated care providers and injured workers to develop treatment and discharge plans, work-hardening programs and physical, occupational and vocational rehabilitation therapy.

(6) Coordinate return to work plans with employers and recommend part-time or light duty work plans.

(7) Identify an injured worker's abilities and skills and match them with work opportunities.

(8) Prohibit the implementation of a treatment plan and referral under paragraph (4), and prohibit the implementation of another implement plan under paragraphs (5) and (6), without securing the injured worker's consent.

(b) A CCO may combine its utilization review and case management functions and departments.

(c) A CCO shall establish, operate and maintain a case communication system which periodically relates necessary and appropriate information concerning the injured worker, as required by the act, among the injured worker, the injured worker's employer, health care providers and the employer's workers' compensation insurer. Dissemination of this information shall be solely for the purpose of providing treatment to or coordinating care for the injured worker.

(d) The CCO shall be prohibited and shall prohibit its providers, employes or agents who may obtain, be provided with or acquire information as a result of the CCO's treatment of an injured worker, from releasing the information to another person without the consent of the injured worker, except as required by the act or regulations.

§ 122.612. Standards for utilization review

(a) A CCO shall have an organized system for the review of the utilization of services rendered by the CCO and its participating coordinated care providers to injured workers to avoid the provision of poor quality care to injured workers which may arise from either underutilization or overutilization of services. A CCO may engage in prospective, concurrent or retrospective review without obtaining a separate approval from the Department of Labor and Industry as a utilization review organization, subject to the following conditions:

(1) The CCO shall place responsibility for compliance with utilization review requirements, particularly precertification requirements, upon its participating coordinated care providers and not upon injured workers.

(2) The CCO shall prohibit participating coordinated care providers from collecting payment from injured workers for care provided by the provider but rejected for payment by the CCO and the payor as being medically unnecessary, or for a financial penalty or fee reduction imposed on the provider due to its failure to follow CCO precertification requirements.

(3) The CCO shall conduct utilization review on treatment provided to an injured worker only for the 30-day period it is entrusted with treatment of the injured worker by virtue of the injured worker having initially selected the CCO from the health care provider list offered by the employer under section 306(f.1)(1)(i)of the act (77 P. S. § 531.1(1)(i)), and during the time that the injured worker continues to utilize the CCO for treatment of the work-related injury.

(4) The CCO shall have an adequate procedure for a participating coordinated care provider dissatisfied with the initial utilization review decision to appeal that decision. An injured worker dissatisfied with an initial utilization review decision shall have the right to appeal that decision through the grievance process.

(5) The CCO shall make decisions regarding pretreatment certification and appeals from utilization review decisions within 7 days of the request and provide notice of its decision to the provider and injured worker.

(6) The CCO shall do the following:

(i) Maintain a written record of staffing within its utilization review system; the professional experience of the staff; staffing to injured worker ratios; and the basis and source of the criteria, standards and guidelines the CCO uses in conducting utilization and return to work case management review.

(ii) Disclose to its participating coordinated care providers its utilization review criteria, standards and guidelines.

(iii) Make available its utilization review criteria, standards and guidelines to injured workers utilizing the CCO, their employers and workers' compensation insurers.

(iv) Utilize qualified and experienced registered nurses to make initial utilization review decisions.

(v) Base treatment or service denials on the clinical review by a qualified physician or practitioner of the service under review.

(b) If the CCO, rather than performing utilization review itself or by an affiliate under common ownership and control, contracts with an independent utilization review organization, the utilization review organization shall be one which has been approved by the Department of Labor and Industry and has entered into a contract with the CCO in accordance with § 122.626 (relating to contracts with independent organizations for performance of case management and communication or utilization review services).

§ 122.613. Standards for quality assurance program

A CCO shall establish, operate and maintain a quality assurance program which includes a record on file of and provides for the following:

(1) A formal quality assurance committee consisting of participating coordinated care providers, under the direction of a medical director, which shall be responsible for approving quality assurance standards and criteria, assessing the performance of the CCO's health service delivery system, identifying quality problems and taking appropriate corrective action.

(2) A written description of the structure and organization of its quality assurance committee and plans for documenting quality assurance activities.

(3) Formal minutes and reports documenting the activities of the quality assurance committee, which shall be available for review by the Department and external quality review agencies.

(4) An adequate staff of quality assurance professionals, particularly quality assurance registered nurses, to implement the quality assurance plan and objectives developed by the quality assurance committee and medical director.

(5) The resume and job description of its medical director and other professionals responsible for conducting quality assurance activities.

(6) A 2-year quality assurance work plan listing specific quality assurance activities the CCO will undertake in terms of focused medical care chart audits, adverse outcome reviews, credentialing activities and other activities; the estimated time frames for completion of each activity; and responsible personnel. As part of its 2-year quality assurance work plan, the CCO shall review a statistically significant sample of medical records pertaining to the treatment of injured workers. Injured workers treated by the CCO shall be selected for review and the medical records of the participating coordinated care providers that treated the injured worker shall be independently reviewed by the quality assurance system to ascertain the following:

(i) The quality of care provided by each provider.

(ii) The timeliness and appropriateness of treatment provided.

(iii) Verification that each physician who is a participating coordinated care provider has staff admitting privileges in at least one hospital that is a participating coordinated care provider.

(iv) A requirement that there be disclosure to the CCO by the provider of a financial interest in another provider to which the credentialed provider may be making referrals.

(v) Verification of the provider's training and experience.

(vi) Verification of compliance with another standard the CCO adopts as part of its credentialing process, and with treatment protocols established by the CCO through its quality assurance system.

(vii) Establishment of standards for medical records and periodic review of medical records/charts to verify provider compliance with the standards.

(viii) For providers for which Health Care Cost Containment Council data is available, consideration of the data in the credentialing and recredentialing of participating coordinated care providers.

(7) An injured worker satisfaction program which meets the requirements of § 122.614 (relating to injured worker satisfaction program).

§ 122.614. Injured worker satisfaction program

(a) A CCO shall continually conduct injured worker satisfaction surveys designed to ascertain at least the following regarding injured workers:

(1) Satisfaction with the participating coordinated care providers, as well as nonparticipating referral providers who have treated them.

(2) Satisfaction with the coordination of care, case management and referrals.

(3) Promptness of appointments and treatment.

(4) Overall satisfaction with the quality of care provided.

(5) Satisfaction with the return to work plan and outcome.

(b) The Department may establish a uniform injured worker satisfaction assessment survey to enhance comparative performance measurement of CCO responsiveness to injured worker needs.

§ 122.615. Injured worker grievance system and provision of alternatives

(a) The CCO shall maintain and offer the injured worker the following alternatives if the injured worker is dissatisfied with the quality of care or quality of service of a participating coordinated care provider:

(1) The right to choose another participating coordinated care provider to provide the required medically necessary services at no cost to the injured worker.

(2) The opportunity to transfer to one of the other providers specified in the list provided by the employer under section 306(f.1)(1)(i) of the act (77 P. S. § 531.1(1)(i)), during the first 30 days of treatment or to transfer to an eligible provider thereafter.

(3) The right to file a complaint under the provisions of the CCO's injured worker grievance system.

(b) The CCO shall offer the following alternatives to an injured worker who contests denial of medically necessary treatment or services by the CCO or a participating coordinated care provider as a result of a CCO utilization review or case management decision, or otherwise:

(1) The right to have the CCO arrange for a second clinical opinion by a participating coordinated care provider, at no cost to the injured worker, concerning the medical necessity or appropriateness of treatment to which the injured worker alleges being denied access.

(2) The right to have the injured worker's claim reviewed, at the CCO's expense, by a non-CCO affiliated utilization review organization approved by the Department of Labor and Industry.

(3) The right to transfer to one of the other providers specified on the list provided under section 306(f.1)(1)(i) of the act, during the first 30 days of treatment or to transfer to any eligible provider thereafter.

(4) The right to file a complaint under the CCO's injured worker grievance system.

(c) The CCO shall establish, operate and maintain an injured worker grievance system as one of the remedies available to the injured worker.

(d) The injured worker grievance system shall include:

(1) A verbal or written complaint filed by an injured worker with the CCO, as the first level of grievance. The CCO shall make a good faith attempt to address the complaint and offer an appropriate remedy or corrective action within 7 working days of its receipt of the complaint.

(2) A formal written grievance filed by the injured worker with the CCO if the injured worker is dissatisfied with the CCO's response to the first level grievance resolution or response, as the second level of grievance.

(i) The CCO shall appoint a grievance committee to conduct an informal hearing on the injured worker's grievance. The CCO may not permit a person who has had prior involvement in the review of the grievance committee. The CCO shall provide the injured worker or the injured worker's representative the opportunity to be heard. The CCO is encouraged, but not required, to include worker representation on the grievance committee.

(ii) The CCO shall require that the grievance committee's informal hearing be held in a timely fashion and its written decision be rendered promptly after the hearing. Generally, the conducting of the informal hearing within 20 days of the injured workers' filing of a grievance, and the rendering of the decision of the grievance committee within 10 days of the informal hearing shall be considered prompt.

(iii) The CCO shall ensure that the decision on the formal written grievance includes the committee's rationale for its decision and written notification to the injured worker of the right to appeal the decision to the Department.

(iv) The CCO shall require that a transcript be taken of the informal hearing and that the record of the informal hearing be forwarded to the Department if the injured worker appeals the decision of the grievance committee.

(3) The CCO shall ensure that for issues involving medically urgent treatment in which time may be of the essence, the injured worker may ask for expedited review and is aware of that option. The CCO shall provide expedited review of the grievance by its medical director. The medical director shall decide the grievance, inform the injured worker in writing of the decision and rationale for it, and inform the injured worker of the worker's right to appeal the decision to the Department. In these cases, the medical director's decision shall be rendered within 48 hours of the injured worker's request for an expedited grievance review.

(e) The injured worker shall have the right to appeal a decision of the CCO's grievance committee or medical director to the Department. The Department will have authority to overturn the decision of the grievance committee or medical director and order the CCO to afford the injured worker an appropriate remedy or to improve its quality of care to the injured worker.

(f) The CCO shall be responsible for paying the cost of independent clinical opinions from qualified providers or utilization review organizations approved by the Department of Labor and Industry which are requested by the Department to assist it in considering a grievance appeal.

(g) The CCO shall maintain a log of complaints and grievances filed by injured workers, in which the CCO shall record response times and dispositions, and shall make the log available for review and inspection by the Department.

(h) The CCO shall provide to an injured worker who communicates dissatisfaction with the quality of care or service received or who claims denial of medically necessary treatment or services, a written description of alternative remedies available to the injured worker and of the grievance system.

§ 122.616. External quality assessment of CCOs

(a) To ensure that CCOs are providing the high-quality care required by the act and that provision of care through CCOs is not resulting in inadequate treatment, poor quality care or inappropriate release of injured workers to return to work, the Department may arrange for external quality reviews of CCOs.

(b) The Department may direct that an external quality review of a CCO be conducted at any time.

(c) The Department may arrange for external quality reviews of a sample of CCOs to independently determine the quality of care being provided by CCOs. If a sample analysis reveals significant quality of care problems or lack of CCO commitment to documented and effective oversight of quality of care being provided to injured workers, the Department may then require all CCOs to undergo an external quality assessment.

(d) An external quality assessment shall be conducted by an external quality review organization acceptable to the Department and selected by the CCO from a list of Department-approved review entities.

(e) An external quality assessment is designed to study the quality of care being provided to injured workers and the effectiveness of the CCO's formal quality assurance structure and activities. It shall include a review of randomly selected medical records of injured workers treated by the CCO to judge matters such as compliance with medical record standards, appropriateness of diagnosis and treatment, appropriateness of referrals, continuity of care and underutilization of services.

(f) The CCO shall be responsible for contracting with the external quality review organization and paying for its services.

(g) The external quality review organization and the CCO shall arrange an acceptable date, time, place and agenda for the external review with the Department and provide Department staff with full rights of participation in and observation of the external review.

(h) The CCO shall arrange for the external quality review organization to issue a formal written report of its findings to the board of directors of the CCO and to the Department. The Department will utilize this report as an independent fact finding report and consider it in the Department's decision as to whether to require a corrective action plan of the CCO, and what the components of that plan should be, or whether the Department should pursue action to suspend or revoke the CCO certification.

§ 122.617. Corrective action plans

(a) If the Department determines through direct examination or through an external quality review that there are deficiencies in a CCO's operations, the Department will identify the deficiencies to the CCO in writing.

(b) The CCO shall submit a corrective action plan within 30 days of its receipt of a deficiency letter from the Department.

(c) The Department may initiate action to revoke or suspend the certification of a CCO that fails to meet the Department's requirements for an acceptable corrective action plan within 90 days of the date of the initial deficiency letter or for failure of a CCO to implement a corrective action plan which the Department has approved.

§ 122.618. Exemptions for rural CCOs

(a) An applicant for certification as a CCO seeking to operate in a county designated as rural by the Health Care Financing Administration or in a rural Health Professional Shortage area may request an exemption from compliance with one or more requirements of section 306(f.2)(2) and (3) of the act (77 P. S. § 531.1(2) and (3)). A request shall justify the exemption sought.

(b) In reviewing the request for exemption, the Department will consider whether the potential public benefit outweighs the potential public harm attributable to the requested exemption.

§ 122.619. Access to records; inspections of CCOs

(a) The CCO shall permit the Department and its employes and agents complete and free access to the books, records, papers and documents of the CCO to enable the Department to perform its responsibilities under the act to ensure that the services provided by a CCO are in accordance with the plan for providing services included in its approved application, and that the services which are provided meet accepted professional standards for high quality, cost-effective care.

(b) The Department may review the actions or operations of a CCO to ensure its continuing compliance with standards, to address quality of care complaints or grievances or to validate data submitted in CCO reports. A review may include onsite inspection of the CCO's facilities and records.

(c) The CCO shall permit the Department and its employes and agents access to the medical records of injured workers treated by or through a CCO for the purposes of assessing quality of care and for the purposes of reviewing injured worker grievances and complaints.

§ 122.620. Role of the CCO in billing

(a) A CCO, to ensure reimbursement of its participating coordinated care providers in accordance with the reimbursement arrangements it may negotiate with an employer or workers' compensation insurer, may do the following:

(1) Require the bills of participating coordinated care providers for treatment of injured workers selecting the CCO to be sent to the CCO for repricing in accordance with its contract with the employer or workers' compensation insurer.

(2) Forward repriced, accurate bills to the self-insured employer or the employer's workers' compensation insurer for direct payment to the participating coordinated care provider.

(b) The CCO may propose for Department review other methods to ensure that participating coordinated care provider bills are accurately and promptly identified as CCO related bills subject to the negotiated fee established between the CCO and the self-insured employer or workers' compensation insurer.

§ 122.621. Referrals within a CCO

(a) Neither a CCO nor any of its participating coordinated care providers is prohibited from referring an injured worker for a medical good or service specified in section 306(f.1)(3)(iii) of the act (77 P. S. § 531.1(3)(iii)) to another participating coordinated care provider within the CCO network, irrespective of whether the CCO or the referring participating coordinated care provider has a financial interest in the participating coordinated care provider to whom the referral is made.

(b) The CCO and its participating coordinated care providers shall provide to the injured worker a written disclosure of their financial interests, if any, in a provider to which referrals may be made.

(c) The CCO shall monitor the referrals to ensure quality, guard against overutilization, ensure that no referrals prohibited under section 306(f.1)(3)(iii)of the act are made to nonparticipating coordinated care providers, and ensure that no referrals are made to persons other than the participating coordinated care providers within the network unless preapproved by the CCO.

§ 122.622. Prohibition of risk-transfer to CCOs

A CCO may not accept financial risk for the provision of services to injured workers without securing appropriate licensure under the laws of the Commonwealth as a risk-assuming insurer, establishing appropriate systems to guard against the potential for undertreatment or poor quality care arising out of the incentive to minimize financial risk, and securing specific prior review and approval by the Department to assume the financial risk for the provision of services as a CCO.

§ 122.623. Data reporting requirements

(a) A CCO shall file an annual report with the Department for each 12 months of operation. This report shall be filed with the Department within 60 days after the end of each 12-month period and shall summarize the CCO's activities during the preceding 12-month period and include the following:

(1) The number of self-insured employers which had offered the CCO to injured workers during the reporting period as one of the specified providers under section 306(f.1)(1)(i)of the act (77 P. S. § 531.1(1)(i)).

(2) The number of workers' compensation insurers which had offered the CCO during the reporting period as one of the specified providers under section 306(f.1)(1)(i) of the act.

(3) The total number of workers eligible to utilize the CCO during the reporting period.

(4) The number of workers who actually utilized the CCO during the reporting period and the length of time of the utilization.

(5) The number of each of the following for the reporting period: complaints and grievances filed, resolved in favor of the injured worker, decided in favor of the CCO or participating coordinated care provider, pending resolution and appealed by injured workers to the Department.

(6) The number of each of the following for the reporting period: utilization review decisions appealed by participating coordinated care providers, settled in favor of the provider, settled in favor of the CCO and pending resolution.

(7) The number of injured workers during the reporting period who initially selected the CCO and were still under treatment 31 days after the injury and receiving care through the CCO, and who initially selected the CCO and were still under treatment 31 days after the injury and who exercised their option to seek continued treatment from non-CCO providers.

(8) The number of injured workers during the reporting period who selected the CCO option who returned to work within: 0 — 7 days; 8 — 14 days; 15 — 30 days; 31 — 40 days; 41 — 50 days; 51 — 60 days; 61 — 365 days; or more than 365 days after injury.

(9) The number of workers during the reporting period who were reinjured or requiring medical services relating to the original injury within 0 — 7 days; 8 — 30 days; 31 — 90 days; 91 — 365 days of their return to work.

(10) The record of timeliness of delivery of services during the reporting period, as required by § 122.609(d) (relating to requirements for a CCO's health service delivery system).

(11) The cost of providing services to injured workers, for the reporting period, in a form and with specificity the Department may require.

(b) The Department may require uniform collection of data as to data required by this section or to track specific diagnoses related to the treatment of injured workers, and to require the production of the data for standardized time periods to facilitate the Department's compilation of statistics to compare CCO performance.

§ 122.624. Requirements for service area expansion

(a) A CCO may apply for approval of an expansion of its service area by submitting a request for the expansion to the Department. The expansion request shall include the following:

(1) The proposed new service area, by county.

(2) A list of participating coordinated care providers in the proposed new service area who are capable of providing primary medical services and other required health services in a manner that meets the standards in § 122.609 (relating to requirements for a CCO's health service delivery system).

(3) A description of how required services such as case management and communication, utilization review and quality assurance will be extended to serve injured workers in the

proposed additional service area and a description of the CCO's plans for increased staffing to expand these services.

(b) The Department will treat an application to expand a CCO's service area as an application to amend the CCO's certification.

(c) The filing fee for a service area expansion will be established by regulation. The Department anticipates that this fee will be approximately $500.

(d) A CCO may not provide coordinated care services in a new service area until the Department has specifically approved the service area expansion request.

§ 122.625. Injured worker literature

As soon as practical after an injured worker's initial contact with a CCO, the CCO shall provide the injured worker with a written description of the CCO structure, operation, provider network, quality assurance system, utilization review system, grievance resolution system, alternatives to the grievance resolution system, referral requirements and methods by which the injured worker may change providers or initiate a referral within the provider network. The CCO may arrange with an employer for the employer or insurer to distribute the literature to injured workers.

§ 122.626. Contracts with independent organizations for performance of case management and communication or utilization review services

(a) A CCO shall provide quality assurance and injured worker grievance system services directly.

(b) A CCO may, with the prior approval of the Department, contract with an independent organization for the conduct of utilization review or case management and communication services for injured workers treated by the CCO.

(c) A CCO that intends to enter into a contract subject to subsection (b), after it becomes certified, shall submit the contract for review and approval by the Department before it enters into the contract.

(d) The CCO will be held by the Department to have ultimate responsibility and accountability for services provided by a contractor to injured workers pursuant to a contract subject to subsection (b).

(e) A contract subject to subsection (b) shall contain provisions which provide that:

(1) The ultimate responsibility and accountability for services provided by the contractor to injured workers is retained by the CCO.

(2) The CCO has authority to establish performance standards, monitor performance of the contractor, require corrective action and terminate the contract if the contractor is found by the CCO to be ineffective or to be conducting activities detrimental to the CCO or injured workers.

(3) The Department has approval authority over the contract and authority to require the CCO to take corrective action.

(4) The CCO and the Department shall have access to records, including medical records, relating to the provision of services to injured workers electing to receive care through the CCO.

§ 122.627. Changes or additions to previously approved application

(a) Except as set forth in subsection (b), a CCO may not engage in a material departure in its operations from the manner described in the information submitted with its application for certification without filing the proposed changes with the Department 60 days prior to the intended effective date of the changes. The filings shall be subject to the following:

(1) A CCO may not implement changes in contracts with participating coordinated care providers, other than as to negotiated fee levels, without specific approval of the Department.

(2) A CCO may implement a change or addition after expiration of the 60-day filing period if this subchapter does not specifically state that that type of change or addition requires prior Departmental approval and if the Department does not notify the CCO within 60 days of its receipt of the proposed change or addition that the change or addition is significant enough to require specific prior review and approval of the Department. If so notified by the Department, the CCO may not implement the change or addition until the Department has formally approved the change or addition.

(b) A CCO may add and delete participating coordinated care providers within its approved service area, as long as it maintains sufficient numbers and specialty distribution to provide primary care medical services. Changes in updated provider lists shall be filed with the Department semiannually on or before July 30, covering the period January to June, and with the annual report required by § 122.623 (relating to data reporting requirements).

TITLE 34. LABOR AND INDUSTRY

PART VIII. BUREAU OF WORKERS' COMPENSATION

CHAPTER 123. GENERAL PROVISIONS PART II

SUBCHAPTER I. UNINSURED EMPLOYER GUARANTY FUND – STATEMENT OF POLICY

§ 123.801. Uninsured Employer Guaranty Fund

The Department of Labor and Industry (Department) adopts this statement of policy so that all parties will have a clear understanding of their rights and obligations under the act, as amended by Act 147 of 2006 (P.L. 1362, No. 147) (Act 147). This subchapter does not constitute a rule or regulation with the force and effect of law. The Department intends to promulgate regulations for this purpose as soon as practicable.

§ 123.802. Notice to the Uninsured Employer Guaranty Fund

(a) For purposes of Article XVI of the act (77 P. S. § § —), an injured worker who seeks benefits from the Uninsured Employer Guaranty Fund (Fund) shall notify the Fund of a claim within 45 days from the date upon which the injured worker knew that the employer was uninsured.

(b) Compensation will not be paid from the Fund until notice is given.

(c) Notice to the Fund shall consist of completing and mailing the form designated as "Notice of Claim Against Uninsured Employer" (Notice) to the Department of Labor and Industry (Department) at the address listed on the form. The Department may reject any incomplete Notice.

(d) The Notice will be deemed filed as of the date of the Notice's deposit in the United States Mail, as evidenced by a United States Postal Service postmark, properly addressed, with postage or charges prepaid. If a United States Postal Service Postmark is not present, the date of the Department's actual receipt of the Notice is the filing date.

§ 123.803. Prerequisites for filing claim petition for benefits from Fund

(a) Upon the filing of a completed "Notice of Claim Against Uninsured Employer" (Notice), the Uninsured Employer Guaranty Fund (Fund) will determine whether it will commence making payments.

(b) An injured worker may not seek an award against the Fund unless the worker completes and files the form designated as the "Claim Petition for Benefits from the Uninsured Employer Guaranty Fund."

(c) A "Claim Petition for Benefits from the Uninsured Employer Guaranty Fund" may not be filed until at least 21 days after the injured worker filed the Notice as required in § 123.802 (relating to notice to the Uninsured Employer Guaranty Fund).

(d) A completed "Claim Petition for Benefits from the Uninsured Employer Guaranty Fund" will be deemed filed upon the later of either of the following:

(1) The date of the petition's deposit in the United States Mail, as evidenced by a United States Postal Service postmark, properly addressed, with postage or charges prepaid; or, if no United States Postal Service Postmark is present, as of the Department's receipt of the petition.

(2) Twenty-one days after the filing of the Notice identified in § 123.802.

(e) The Department may reject any incomplete petition.

§ 123.804. Filing of claim petition for benefits from the Fund

(a) If an injured worker attempts to file a "Claim Petition for Benefits from the Uninsured Employer Guaranty Fund" before filing the "Notice of Claim Against Uninured Employer" (Notice) required under § 123.802 (relating to notice to the Uninsured Employer Guaranty Fund), the Department will return the petition to the injured worker and instruct the worker to complete a Notice.

(b) A Claim Petition for Workers' Compensation (LIBC—362) filed against an employer may not act as a claim against the Uninsured Employer Guaranty Fund (Fund) or be deemed notice to the Fund.

(c) An injured worker seeking an award of benefits from the Fund shall file the "Claim Petition for Benefits from the Uninsured Employer Guaranty Fund" with the Bureau and shall serve the Fund and the alleged employer at the addresses identified on the petition. The Fund is not required to answer a petition which does not conform to this section.

§ 123.805. Rights of Fund

The Uninsured Employer Guaranty Fund (Fund) is not prejudiced by an agreement, admission or stipulation concerning the compensability, facts or legal conclusions relating to an injury underlying a claim against the Fund unless the Fund is a party to and specifically endorses the agreement, admission or stipulation.

TITLE 34: LABOR AND INDUSTRY

PART VIII: BUREAU OF WORKERS' COMPENSATION

CHAPTER 126. HEALTH CARE UNDER THE WORKERS' COMPENSATION ACT – STATEMENT OF POLICY

§ 126.1. Medical fee updates

When submitting data under § 127.155(c) (relating to medical fee updates on and after January 1, 1995—outpatient acute care providers, specialty hospitals and other cost-reimbursed providers), all codes submitted to the Bureau of Workers' Compensation shall be based upon the appropriate International Classification of Disease (ICD), Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. If these codes are not available, providers shall submit data in a form mandated by the United States Department of Health and Human Services as published in 45 CFR Parts 160 and 162 (2000) (relating to general administrative requirements; and requirements), as amended. Providers submitting this data may append an appropriate modifier to the code to account for interfacility distinctions in treatment or billing procedures.

TITLE 34. LABOR AND INDUSTRY

PART VIII. BUREAU OF WORKERS' COMPENSATION

CHAPTER 130. OCCUPATIONAL DISEASE UNDER THE WORKERS' COMPENSATION ACT — STATEMENT OF POLICY

§ 130.1. Guidelines for employment screening programs under Act 115 of 2001

(a) Hepatitis C is a blood-borne virus that attacks the liver. Since its identification in 1989, the virus has become the leading cause of liver transplants in the United States and is responsible for 8,000 to 10,000 deaths per year. Nearly 4 million Americans are currently infected to date. The number of infected Americans is expected to triple within the next 10 to 20 years, according to the National Institute of Health. Emergency medical and public safety employees have been identified as a group with a higher risk of exposure to the virus because of the nature of their employment.

(b) On December 20, 2001, Governor Mark Schweiker signed into law Act 115 of 2001, which amends section 108 of the Workers' Compensation Act (77 P. S. § 27.1) (act) to create a presumption that Hepatitis C in the following occupations is an occupational disease within the meaning of the act:

(1) Professional and volunteer firefighters.

(2) Volunteer ambulance corp personnel.

(3) Volunteer rescue and lifesaving squad personnel.

(4) Emergency medical services personnel and paramedics.

(5) Pennsylvania State Police officers.

(6) Police officers requiring certification under 53 Pa.C.S. Chapter 21 (relating to employees).

(7) Commonwealth and county correctional employees, and forensic security employees of the Department of Public Welfare, having duties including care, custody and control of inmates involving exposure to Hepatitis C.

(c) The presumption is not conclusive and shall be rebutted "if the employer has established an employment screening program, in accordance with guidelines established by the [D]epartment in coordination with the Department of Health and the Pennsylvania Emergency Management Agency and published in the Pennsylvania Bulletin, and testing pursuant to that program establishes that the employee incurred the Hepatitis C virus prior to any job-related exposure."

(d) The purpose of this section is to provide guidelines for the screening program that includes testing for the Hepatitis C virus so that an employer may rebut the presumption that the presence of the virus is work-related.

(e) An employment screening program for Hepatitis C should be implemented by having an employee undergo medical testing utilizing Food and Drug Administration-approved tests for Hepatitis C, as directed by a physician. As part of the employment screening program, supplemental testing should be conducted where the initial test yields a positive result, or when deemed appropriate by a physician. Future interval testing, to be administered in accordance with accepted standards of care, should be conducted when a physician determines that such testing is appropriate.

(f) The screening program should include testing. Act 115 of 2001 should not be interpreted to preclude other related procedures, such as the distribution of questionnaires requesting information on prior employment, including a description of job duties and responsibilities.

(g) This section is intended to provide guidance to the Bureau of Workers' Compensation staff, workers' compensation insurance carriers, employers, employees, workers' compensation practitioners and other interested parties concerning the implementation of Act 115 of 2001. This chapter does not constitute a rule or regulation with the force of law.

Appendixes

APPENDIX A

ADDITIONAL PROVISIONS OF THE ACT

The following provisions were enacted as part of Act 57 of 1996:

Sec 30 For the purpose of initial filing only, notwithstanding any other provisions of this act, the following shall apply:

(1) No later than 45 days after the effective date of this section, the Insurance Commissioner shall appoint an independent actuary to provide an estimate of the total change in workers' compensation loss-cost resulting from implementation of this act and resulting from implementation of the act of July 2, 1993 (P.L. 190, No.44), entitled "An act amending the act of June 2, 1915 (P.L. 736, No.338), entitled, as reenacted and amended, 'An act defining the liability of an employer to pay damages for injuries received by an employe in the course of employment; establishing an elective schedule of compensation; providing procedure for the determination of liability and compensation thereunder; and prescribing penalties,' adding and amending certain definitions; redesignating referees as workers' compensation judges; further providing for contractors, for insurance and self-insurance, for compensation and for payments for medical services; providing for coordinated care organizations; further providing for procedures for the payment of compensation and for medical services and for procedures of the department, referees and the board; adding provisions relating to insurance, self-insurance pooling, self-insurance guaranty fund, health and safety and the prevention of insurance fraud; further providing for certain penalties; making repeals; and making editorial changes," and an estimate of any other change attributable to data not considered in any previous loss-cost filing. The fee for this independent actuary shall be borne by the Workmen's Compensation Administration Fund. In developing the estimate, the independent actuary shall consider all of the following:

(i) The most recent policy year unit statistical and financial loss-cost data available after policy year 1993. Notwithstanding any other provision of this section, for purposes of this subparagraph, the Coal Mine Compensation Rating Bureau shall submit the most recent accident or calendar year statistical and financial loss-cost data available after accident or calendar year 1993.

(ii) The standards set forth in section 704 of the act, as applicable.

(iii) Any other relevant factors within and outside this Commonwealth in accordance with sound actuarial principles.

(2) No later than 15 days after the effective date of this section, each insurer, including the State Workmen's Insurance Fund, shall file loss data as required under paragraph (1) with its rating organization. For failure to comply, the commissioner shall impose an administrative penalty of $1,000 for every day that this data is not provided in accordance with this paragraph.

(3) No later than 45 days after the effective date of this section, each rating organization shall provide to the independent actuary, the commissioner and the small business advocate aggregate loss-cost data equal to or greater than 75% of the total data expected from all insurers, including the State Workmen's Insurance Fund. For failure to comply by any rating organization, the commissioner shall impose an administrative penalty of $1,000 for every day that the data is not provided in accordance with this paragraph unless caused by the late reporting of any insurer. The commissioner shall impose an administrative fine of $1,000 upon any insurer whose late reporting of data causes such a delay, for every day beyond the required time frame of this paragraph until the aggregate loss-cost data is reported. This fine is in addition to any fine imposed for the late reporting of data to the rating organization under paragraph (2).

(4) No later than 95 days after the effective date of this section, the independent actuary shall complete and send the estimate of total loss-cost change to the commissioner, each rating organization, the Small Business Advocate, the President pro tempore of the Senate and the Speaker of the House of Representatives. The commissioner shall make the estimate available for public inspection.

(5) No later than 25 days after the independent actuary completes and sends the report referred to in paragraph (4), each rating organization shall, pursuant to section 709(c) of the act, file new loss-cost changes which reflect the estimate of the sum total of loss-cost data compiled under this section. For failure to comply, the commissioner shall impose an administrative penalty of $1,000 for every day that the loss-cost filing is not provided in accordance with this paragraph.

(6) The commissioner shall give full consideration to the independent actuary's estimate from paragraph (4) in approving, disapproving or modifying the filing made under paragraph (5), pursuant to Article VII of the act. No later than 30 days after the approval of the filing, each new and renewal policy for workers' compensation shall reflect the new loss-cost filing of its rating organization.

(7) The commissioner shall appoint and retain an independent actuary in accordance with this section until the independent actuary has prepared and sent the estimate as required by paragraph (4). The commissioner may appoint and retain an independent actuary after the estimate required by paragraph (4) has been completed and sent.

(8) For the purpose of this section, an "independent actuary" means a member in good standing of the Casualty Actuarial Society or a member in good standing of the American Academy of Actuaries, who has been approved as qualified for signing casualty loss reserve opinions by the Casualty Practice Council of the American Academy of Actuaries and who is not an employee of the Commonwealth.

Sec 31 In a provision of the act not affected by this act, a reference to the word "referee" shall be deemed a reference to the phrase "workers' compensation judge."

Sec 31.1 Any reference in a statute to the Workmen's Compensation Appeal Board shall be deemed a reference to the Workers' Compensation Appeal Board.

Sec 31.2 Regulations of the Department of Health promulgated under section 306(f.2)(7) of the act shall be deemed regulations of the Department of Labor and Industry. The Legislative Reference bureau shall recodify the regulations.

Sec 32 The provisions of this act are severable. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this act which can be given effect without the invalid provision or application.

Sec 32.1 (a) The amendment or addition of sections 204(a), 306(a.2) and (b)(2) and 309 of the act shall apply only to claims for injuries which are suffered on or after the effective date of this section.

(b) The addition of section 1402(a)(1) of the act shall not apply to the individual acting as director of adjudication on the effective date of this section.

Sec 32.2 The act of June 2, 1915 (P.L. 762, No. 340), referred to as the State Workmen's Insurance Fund Law, is repealed.

Sec 33 This act shall take effect as follows:

(1) The following provisions shall take effect immediately:

(i) The addition of section 306(a.2) of the act.

(ii) The addition of Article XV of the act.

(iii) Section 32.1 of this act.

(iv) Section 32.2 of this act.

(v) This section.

(2) The remainder of this act shall take effect in 60 days.

[Editor's Note: Act 57 was approved June 24, 1996.]

The following provisions were enacted as part of Act 44 of 1993:

Sec 23 The Commonwealth, its political subdivisions, their officials and employees acting within the scope of their duties shall enjoy and benefit from sovereign and official immunity from claims of subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits.

Sec 25 (a) The following act and parts of acts are repealed to the extent specified:

Section 654 of the act of May 17, 1921 (P.L. 682, No. 284), known as The Insurance Company Law of 1921, except with regard to insurance as to liability under the Longshore and Harbor Workers' Compensation Act (44 Stat. 1424, 23 U.S.C. § 901 et seq.).

75 Pa.C.S. §§ 1735 and 1737, absolutely.

(b) The provisions of 75 Pa.C.S. §§ 1720 and 1722 are repealed insofar as they relate to workers' compensation payments or other benefits under the Workers' Compensation Act.

(c) All other acts and parts of acts are repealed insofar as they are inconsistent with this act.

Sec 26 No changes in indemnity compensation payable by this act shall affect payments of indemnity compensation for injuries sustained prior to the effective date of this section.

[Editor's Note: Act 44 was approved July 2, 1993.]

The following provisions were enacted as part of Act 1 of 1995:

Sec 3 This act shall apply as follows:

(1) Except as provided in paragraph (2), the amendment or addition of sections 105.4, 105.5, 105.6 and 306(c)(8) of the act shall apply to claims filed on or after the effective date of this act.

(2) The amendment or addition of sections 105.5 and 306(c)(8)(I), (II) and (IV) shall apply retroactively to all claims existing as of the effective date of this act for which compensation has not been paid or awarded.

Sec 4 This act shall take effect immediately.

[Editor's Note: Act 1 was approved February 22, 1995.]

APPENDIX B

ACCIDENTS REPORTED TO DEPARTMENT OF LABOR AND INDUSTRY

Act of 1913, P.L. 843, Amended 1937,
P.L. 56 (43 P.S. § 12-16)

AN ACT

Requiring employers to make report to the Department of Labor and Industry of accidents to employes, and prescribing a penalty, for non-compliance therewith.

Sec 1 Within fifteen days after the date of any injury received by an employe in the course of or resulting from his employment, and within forty-eight hours of the death of an employe occurring from an injury received in the course of or resulting from his employment, the employer, whether a person, firm, or corporation, or the Commonwealth, or any political subdivision thereof, shall make report of such injury or death directly to the Department of Labor and Industry. Such report shall be made in such form as the Department of Labor and Industry shall prescribe, and shall set forth the name, address, and nature of the business of the employer; name, address, sex, age, nationality, wage or salary, and occupation of the employe; date, day of week, hour, place, cause, and character of the injury or death, and in the case of an injury, the nature of the injury, and the duration of the disability, or probable disability, as far as the same can be ascertained. Such employer shall, also, upon request of the Department of Labor and Industry, make such further report as may reasonably be required by it.

Sec 2 Any person, firm, or corporation having knowledge of the occurrence of such personal injury or death to an employe, in the course of or resulting from his employment, who shall fail to make report as aforesaid, shall, upon conviction thereof in a summary proceeding, be sentenced to pay a fine of not more than one hundred dollars ($100.00), or undergo imprisonment for not more than thirty (30) days, or both, at the discretion of the court.

Sec 3 Reports made in accordance with this act shall not be evidence against the employer in any proceeding, either under the Workmen's Compensation Law of one thousand nine hundred and fifteen or otherwise.

Sec 4 No employer who has made the report required by this act shall be required to make any other or further report of such injury or death to any other department of the government of the Commonwealth.

Sec 5 This act shall not apply to casual employments; nor to injuries resulting in disability continuing less than the day shift or turn in which the injury was received.

APPENDIX C

FORMS

LIBC-9 ..... Workers' Compensation Medical Report Form

LIBC-10 ..... Authorization for Alternative Delivery of Compensation Payments

LIBC-14 ..... Instructions for Religious Exception Application

LIBC-14A ..... Application for Religious Exception of Specified Employees from the Provisions of the PA Workers' Comp Act

LIBC-14B ..... Employee's Affidavit and Waiver of Workers' Compensation Benefits and Statement of Religious Sect

LIBC-25/26 .. Appeal From Judge's Findings of Fact and Conclusions of Law

LIBC-34 ..... Petition for Commutation

LIBC-35 ..... Answer to Petition for Commutation

LIBC-90 ..... Electronic Data Interchange First Report of Injury

LIBC-112 ..... WC Hearing – Interested Party Update Request Instructions

LIBC-113 ..... WC Hearing – Interested Party Update Request

LIBC-134 ..... Dismemberment Chart

LIBC-134F..... Dismemberment Chart

LIBC-210I .... Insurer's Annual Report of Accident and Illness Prevention Services and…

LIBC-220E ... Annual Report of Accident and Illness Prevention Program Status for Self-Insured Employers

LIBC-221I..... Self-Insured Employer's Initial Report of Accident and Illness Prevention Program

LIBC-230G .... Annual Report of Accident and Illness Prevention Program Status by Group Self-Insurance Funds

LIBC-231G .... Initial Report of Accident and Illness Prevention Program Status by New Group Self-Insurance Funds

LIBC-336 ..... Agreement for Compensation for Disability or Permanent Injury

LIBC-337 ..... Supplemental Agreement for Compensation for Disability or Permanent Injury

LIBC-338 ..... Agreement for Compensation for Death

LIBC-339 ..... Supplemental Agreement for Compensation for Death

LIBC-340 ..... Agreement to Stop Weekly Workers' Compensation Payments Final Receipt

LIBC-350 ..... Annual Contribution Worksheet Group Self-Insurance Fund Member Annual Contribution Worksheet Form

LIBC-351 ..... Expense Loss Cost Multiplier Worksheet for Group Self-Insurance Fund Using Rating Organization Loss Costs Multiplier Calculation Worksheet and Instructions

LIBC-352 ..... Expense Loss Cost Multiplier Worksheet for Group Self-Insurance Fund Deviating From Rating Organization Loss Costs Multiplier Calculation Worksheet and Instructions

LIBC-362 ..... Claim Petition for Workers' Compensation

LIBC-363 ..... Fatal Claim Petition for Compensation by Dependents of Deceased Employees

LIBC-364B .... Defendant's Answer to Claim Petition Under Pennsylvania Occupational Disease Act

LIBC-365 ..... Supplemental Information Addendum to Group Self-Insurance Fund Annual Report

LIBC-368 ..... Supplemental Information Addendum to Application for Membership in a Group Workers' Compensation Fund

LIBC-369 ..... Supplemental Information Addendum to Application as a Group Workers' Compensation Fund

LIBC-371 ..... Supplemental Information Addendum to Annual Report of Runoff Group Self-Insurance Fund

LIBC-372..... Initial Application for Safety Committee Certification

LIBC-374 ..... Defendant's Answer to Claim Petition under Pennsylvania Workers' Compensation

LIBC-375 ..... Claim Petition or Additional Compensation From the Subsequent Injury Fund Pursuant to Section 306.1 of the Workers' Compensation Act

LIBC-376 ..... Petition for Joinder of Additional Defendant

LIBC-377 ..... Answer to Petition To/For:

LIBC-378 ..... Petition To/For: (Check any that apply)

LIBC-380 ..... Third Party Settlement Agreement

LIBC-384 ..... Fatal Claim Petition for Compensation by Dependents for Death Covered by the Pennsylvania Occupational Disease Act

LIBC-386 ..... Fatal Claim Petition for Compensation by Dependents For Death Resulting From Occupational Disease

LIBC-387 ..... Important Information About the Petition Filing and Hearing Process

LIBC-392A .... Final Statement of Account of Compensation Paid

LIBC-396 ..... Occupational Disease Claim Petition Monthly Compensation for Disability Under Section 301(i) Only

LIBC-480 ..... Subpoena

LIBC-494A .... Statement of Wages (For Injuries Occurring On or Before June 23, 1996)

LIBC-494C .... Statement of Wages (For Injuries Occurring On or After June 24, 1996)

LIBC-495 ..... Notice of Compensation Payable

LIBC-496 ..... Notice of Workers' Compensation Denial

LIBC-497 ..... Physician's Affidavit of Recovery

LIBC-498 ..... Commutation of Compensation

LIBC-499 ..... Petition for Physical Examination or Expert Interview of Employee (Section 314)

LIBC-500 ..... Remember: It is Important to Tell Your Employer About Your Injury

LIBC-501 ..... Notice of Temporary Compensation Payable

LIBC-502 ..... Notice Stopping Temporary Compensation

LIBC-504 ..... Child Support Lien Affidavit

LIBC-507 ..... Application for Fee Review Pursuant to Section 306(f.1) – OCR*

LIBC-509 ..... Application for Executive Officer's Declaration – OCR*

LIBC-513 ..... Executive Officer's Declaration – OCR*

LIBC-524 ..... Defendant's Answer to Occupational Disease Claim Petition Section 301(i) Only

LIBC-550 ..... Claim Petition for Benefits from the Uninsured Employer and the Uninsured Employers Guaranty Fund

LIBC-551 ..... Notice of Claim Against Uninsured Employer

LIBC-601 ..... Instructions for Completing Utilization Review Request

LIBC-601 ..... Utilization Review Request – OCR*

** Optical Character Recognition (OCR)*

APPENDIX C

LIBC-603 ..... Petition for Review of Utilization Review Determination

LIBC-604 ..... Utilization Review Determination Face Sheet

LIBC-606 ..... Request for Hearing to Contest Fee Review Determination

LIBC-749 ..... Death Claim Supplement to Compromise and Release Agreement

LIBC-750 ..... Employee Report of Wages

LIBC-751 ..... Notification of Suspension or Modification Pursuant to 413(c) & (d)

LIBC-753 ..... Notice of Request for an Informal Conference

LIBC-754 ..... Informal Conference Agreement Form

LIBC-755 ..... Compromise and Release Agreement by Stipulation Pursuant to Section 449 of the Workers' Compensation Act

LIBC-756 ..... Employee's Report of Benefits for Offsets

LIBC-757 ..... Notice of Ability To Return To Work

LIBC-758 ..... Notice to Employee-Note: This form is to be attached to the LIBC-378

LIBC-760 ..... Employee Verification of Employment, Self-Employment or Change in Physical Condition

LIBC-761 ..... Notice of Workers' Compensation Benefit Offset

LIBC-762 ..... Notice of Suspension-Failure to Return Form LIBC-760

LIBC-763 ..... Notice of Reinstatement of Workers' Compensation Benefits

LIBC-764 ..... Disability Status

LIBC-765 ..... Impairment Rating Evaluation Appointment

LIBC-766 ..... Request for Designation of a Physician to Perform an Impairment Rating Evaluation

LIBC-767 ..... Impairment Rating Determination Face Sheet

LIBC-810 ..... Claims Listing Template

n/a ..... Notice: Medical Treatment for Your Work Injury or Occupational Illness

APPENDIX D

STATEWIDE AVERAGE WEEKLY WAGE

The maximum weekly compensation payable is defined as the Statewide average weekly wage. See sections 105.1 and 105.2. The following schedule reflects the maximum weekly benefit:

May 1, 1972	through	December 31, 1972	$141.00
January 1, 1973	through	December 31, 1973	$150.00
January 1, 1974	through	December 31, 1974	$159.00
January 1, 1975	through	December 31, 1975	$171.00
January 1, 1976	through	December 31, 1976	$187.00
January 1, 1977	through	December 31, 1977	$199.00
January 1, 1978	through	December 31, 1978	$213.00
January 1, 1979	through	December 31, 1979	$227.00
January 1, 1980	through	December 31, 1980	$242.00
January 1, 1981	through	December 31, 1981	$262.00
January 1, 1982	through	December 31, 1982	$284.00
January 1, 1983	through	December 31, 1983	$306.00
January 1, 1984	through	December 31, 1984	$320.00
January 1, 1985	through	December 31, 1985	$336.00
January 1, 1986	through	December 31, 1986	$347.00
January 1, 1987	through	December 31, 1987	$361.00
January 1, 1988	through	December 31, 1988	$377.00
January 1, 1989	through	December 31, 1989	$399.00
January 1, 1990	through	December 31, 1990	$419.00
January 1, 1991	through	December 31, 1991	$436.00
January 1, 1992	through	December 31, 1992	$455.00
January 1, 1993	through	December 31, 1993	$475.00
January 1, 1994	through	December 31, 1994	$493.00
January 1, 1995	through	December 31, 1995	$509.00
January 1, 1996	through	December 31, 1996	$527.00
January 1, 1997	through	December 31, 1997	$542.00
January 1, 1998	through	December 31, 1998	$561.00
January 1, 1999	through	December 31, 1999	$588.00
January 1, 2000	through	December 31, 2000	$611.00
January 1, 2001	through	December 31, 2001	$644.00
January 1, 2002	through	December 31, 2002	$662.00
January 1, 2003	through	December 31, 2003	$675.00
January 1, 2004	through	December 31, 2004	$690.00
January 1, 2005	through	December 31, 2005	$716.00
January 1, 2006	through	December 31, 2006	$745.00
January 1, 2007	through	December 31, 2007	$779.00
January 1, 2008	through	December 31, 2008	$807.00
January 1, 2009	through	December 31, 2009	$836.00
January 1, 2010	through	December 31, 2010	$845.00
January 1, 2011	through	December 31, 2011	$858.00
January 1, 2012	through	December 31, 2012	$888.00
January 1, 2013	through	December 31, 2013	$917.00
January 1, 2014	through	December 31, 2014	$932.00
January 1, 2015	through	December 31, 2015	$951.00

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