Regulatory Analysis Form

This space for use by IRRC

(1) Agency

Insurance Department

(2) I.D. Number (Governor's Office Use)

11-222

IRRC Number: 2409

(3) Short Title

Workers' Compensation Act-Provider Fees

(4) PA Code Cite

31 Pa. Code, Chapter 167, §§167.1-167.2

(5) Agency Contacts & Telephone Numbers

Primary Contact: Peter J. Salvatore, Regulatory Coordinator, 1326 Strawberry Square, Harrisburg, PA 17120, (717) 787-4429
Secondary Contact:

(6) Type of Rulemaking (check one)

☒ Proposed Rulemaking
☐ Final Order Adopting Regulation
☐ Final Order, Proposed Rulemaking Omitted

(7) Is a 120-Day Emergency Certification Attached?

☒ No
☐ Yes: By the Attorney General
☐ Yes: By the Governor

(8) Briefly explain the regulation in clear and nontechnical language.

The purpose of this proposed rulemaking is to adopt Chapter 167 setting the allowance for anesthesia services provided to patients under the Pennsylvania Workers' Compensation Act when the allowance utilizes the anesthesia conversion factor. The rate established by Section 167.2 shall be used for the period from the effective date of this regulation and updated annually thereafter in accordance with the provisions of 34 Pa. Code §127.162 and Section 306(f.1)(3)(ii) of the Pennsylvania Workers' Compensation Act (77 P.S. §531(3)(ii)).

(9) State the statutory authority for the regulation and any relevant state or federal court decisions.

The proposed rulemaking is made under the general authority of sections 205, 506, 1501 and 1502 of the Administrative Code of 1929 (71 P.S. §§66, 186, 411 and 412) and Subsection 306(f.1)(3)(i) of the Pennsylvania Workers' Compensation Act (77 P.S. §531(3)(i)).

Regulatory Analysis Form

(10) Is the regulation mandated by any federal or state law or court order, or federal regulation? If yes, cite the specific law, case or regulation, and any deadlines for action.

No.

(11) Explain the compelling public interest that justifies the regulation. What is the problem it addresses?

The Insurance Department seeks to adopt Chapter 167, §§167.1-167.2 to be consistent with the authorizing statute. Subsection 306(f.1)(3)(v) (77 P.S. §531(3)(v)) provides that a Medicare allowance for a particular provider group shall be reviewed for reasonableness whenever the Commissioner determines that the use of the allowance would result in payments that are more than 10% lower than the average level of reimbursement the provider would receive from coordinated care insurers ("CCOs"), a classification that includes Health Maintenance Organizations ("HMOs") and Preferred Provider Organizations ("PPOs") under the statute. Under the statute, the Insurance Commissioner is authorized to adopt a new allowance by regulation when the existing allowance is determined to be unreasonable.

(12) State the public health, safety, environmental or general welfare risks associated with nonregulation.

There are no public health, safety, environment or general welfare risks associated with this rulemaking.

(13) Describe who will benefit from the regulation. (Quantify the benefits as completely as possible and approximate the number of people who will benefit.)

The anesthesiologists will benefit from the regulation to the extent that it will increase their allowances under the Workers' Compensation system for procedures utilizing the conversion factor.

Regulatory Analysis Form

(14) Describe who will be adversely affected by the regulation. (Quantify the adverse effects as completely as possible and approximate the number of people who will be adversely affected.)

There will be no adverse effects on any party as a result of the amendment of this regulation.

(15) List the persons, groups or entities that will be required to comply with the regulation. (Approximate the number of people who will be required to comply.)

The regulation applies to all workers' compensation-licensed insurance companies, surplus lines companies writing workers' compensation insurance in the Commonwealth and self-insured employers providing workers' compensation reimbursement to anesthesiologists.

(16) Describe the communications with and input from the public in the development and drafting of the regulation. List the persons and/or groups who were involved, if applicable.

Comments regarding the adoption of this regulation were solicited from the various trade associations representing the insurance industry. Comments from the Insurance Federation of Pennsylvania, Inc. (IFP) and the Department of Labor and Industry (L&I) were taken into consideration in the drafting of this proposed rulemaking.

(17) Provide a specific estimate of the costs and/or savings to the regulated community associated with compliance, including any legal, accounting or consulting procedures, which may be required.

The amendment of the regulation will have only a minimal impact on costs associated with insurance companies or the public. No dollar amount has been associated with the regulation as the total number of procedures is unknown. However, the percentage increase in overall reimbursements under the workers' compensation system is expected to be very small and therefore, the dollar amount associated is assumed to be minimal.

Regulatory Analysis Form

(18) Provide a specific estimate of the costs and/or savings to local governments associated with compliance, including any legal, accounting or consulting procedures, which may be required.

There are no costs or savings to local governments associated with this rulemaking.

(19) Provide a specific estimate of the costs and/or savings to state government associated with the implementation of the regulation, including any legal, accounting, or consulting procedures, which may be required.

There are no costs or savings associated to state government associated with this rulemaking.

Regulatory Analysis Form

(20) In the table below, provide an estimate of the fiscal savings and costs associated with implementation and compliance for the regulated community, local government, and state government for the current year and five subsequent years. N/A

	Current FY Year	FY +1 Year	FY +2 Year	FY +3 Year	FY +4 Year	FY +5 Year
SAVINGS:	$	$	$	$	$	$
Regulated Community						
Local Government						
State Government						
Total Savings						
COSTS:						
Regulated Community	Minimal	Minimal	Minimal	Minimal	Minimal	Minimal
Local Government						
State Government						
Total Costs						
REVENUE LOSSES:						
Regulated Community						
Local Government						
State Government						
Total Revenue Losses						

(20a) Explain how the cost estimates listed above were derived.

No dollar amount has been associated with the regulation as the total number of procedures is unknown. However, the percentage increase in overall reimbursements under the workers' compensation system is expected to be very small and therefore, the dollar amount associated is assumed to be minimal.

Regulatory Analysis Form

(20b) Provide the past three-year expenditure history for programs affected by the regulation.
N/A.

Program	FY –3	FY -2	FY -1	Current FY

(21) Using the cost-benefit information provided above, explain how the benefits of the regulation outweigh the adverse effects and costs.

No costs or adverse effects are anticipated as a result of this regulation.

(22) Describe the nonregulatory alternatives considered and the costs associated with those alternatives. Provide the reasons for their dismissal.

Adopting Chapter 167, §§167.1-167.2 is the most efficient method to achieve consistency with the authorizing statute. No other alternatives were considered.

(23) Describe alternative regulatory schemes considered and the costs associated with those schemes. Provide the reasons for their dismissal.

No other regulatory schemes were considered. The adoption of the regulation is the most efficient method of implementing the regulatory requirements.

Regulatory Analysis Form

(24) Are there any provisions that are more stringent than federal standards? If yes, identify the specific provisions and the compelling Pennsylvania interest that demands stronger regulation.

No.

(25) How does this regulation compare with those of other states? Will the regulation put Pennsylvania at a competitive disadvantage with other states?

The rulemaking will not put Pennsylvania at a competitive disadvantage with other states. It merely provides for consistency with the statute.

(26) Will the regulation affect existing or proposed regulations of the promulgating agency or other state agencies? If yes, explain and provide specific citations.

No.

(27) Will any public hearings or informational meetings be scheduled? Please provide the dates, times, and locations, if available.

No public hearings or informational meetings are anticipated.

Regulatory Analysis Form

(28) Will the regulation change existing reporting, record keeping, or other paperwork requirements? Describe the changes and attach copies of forms or reports, which will be required as a result of implementation, if available.

The amendment of the regulation imposes no additional paperwork requirements on the Department, insurers, anesthesiologists, or the public.

(29) Please list any special provisions which have been developed to meet the particular needs of affected groups or persons including, but not limited to, minorities, elderly, small businesses, and farmers.

The rulemaking will have no effect on special needs of affected parties.

(30) What is the anticipated effective date of the regulation; the date by which compliance with the regulation will be required; and the date by which any required permits, licenses or other approvals must be obtained?

The rulemaking will undergo a 30-day public comment period and will take effect upon approval of the final form regulation by the legislative standing committees, the Office of the Attorney General, and the Independent Regulatory Review Commission and upon final publication in the *Pennsylvania Bulletin.*

(31) Provide the schedule for continual review of the regulation.

The Department reviews each of its regulations for continued effectiveness on a triennial basis.

CDL-1

FACE SHEET
FOR FILING DOCUMENTS
WITH THE LEGISLATIVE REFERENCE BUREAU

(Pursuant to Commonwealth Documents Law)

#2409

DO NOT WRITE IN THIS SPACE

Copy below is hereby approved as to form and legality. Attorney General By _____ (Deputy Attorney General) JUN 11 2004 Date of Approval → Check if applicable. Copy not approved. Objections attached.	Copy below is hereby certified to be a true and correct copy of a document issued, prescribed or promulgated by: Insurance Department (AGENCY) DOCUMENT/FISCAL NOTE NO. 11-222 DATE OF ADOPTION: _____ BY: Diane Koken M. Diane Koken Insurance Commissioner TITLE: _____ (EXECUTIVE OFFICER, CHAIRMAN OR SECRETARY)	Copy below is hereby approved as to form and legality. Executive or Independent Agencies BY _____ 6/3/04 DATE OF APPROVAL (DEPUTY GENERAL COUNSEL) (~~CHIEF COUNSEL, INDEPENDENT AGENCY~~) (STRIKE INAPPLICABLE TITLE) → Check if applicable. No Attorney General approval or objection within 30 days after submission.

NOTICE OF PROPOSED RULEMAKING

INSURANCE DEPARTMENT

31 Pa. Code, Chapter 167
§§167.1-167.2

Workers' Compensation Act-Provider Fees

Preamble

The Insurance Department ("Department") proposes to adopt Chapter 167 (relating to Workers' Compensation Act-Provider Fees) to read as set forth in Annex A. The proposed rulemaking is made under the general authority of sections 205, 506, 1501 and 1502 of the Administrative Code of 1929 (71 P.S. §§66, 186, 411 and 412) and Subsection 306(f.1)(3)(i) of the Pennsylvania Workers' Compensation Act (77 P.S. §531(3)(i)).

Purpose

The purpose of this proposed rulemaking is to adopt Chapter 167 setting the allowance for anesthesia services provided to patients under the Pennsylvania Workers' Compensation Act when the allowance utilizes the anesthesia conversion factor. The rate established by Section 167.2 shall be used for the period from the effective date of this regulation and updated annually thereafter in accordance with the provisions of 34 Pa. Code §127.162 and Section 306(f.1)(3)(ii) of the Pennsylvania Workers' Compensation Act (77 P.S. §531(3)(ii)).

Subsection 306(f.1)(3)(i) of the Pennsylvania Workers' Compensation Act (77 P.S. §531(3)(i)) establishes that compensation to providers of medical services, including anesthesiologists, shall be 113% of the Medicare reimbursement for the medical service or treatment, with such amounts to be modified by annual updates made pursuant to a formula set forth in the Act. Subsection 306(f.1)(3)(i) also provides that when the Insurance Commissioner determines that use of the Medicare reimbursement for a particular provider group or service is not reasonable, the Commissioner may adopt, by regulation, a new allowance. Subsection 306(f.1)(3)(v) (77 P.S. §531(3)(v)) further provides that a Medicare allowance for a particular provider group shall be reviewed for reasonableness whenever the Commissioner determines that the use of the allowance would result in payments that are more than 10% lower than the average level of reimbursement the provider would receive from coordinated care insurers ("CCOs"), a classification that includes Health Maintenance Organizations ("HMOs") and Preferred Provider Organizations ("PPOs") under the statute. In making the determination as to the reasonableness of an allowance under Subsection 306(f.1)(3)(v), the Commissioner must consider the extent to which allowances applicable to other providers under Workers' Compensation deviate from the reimbursement those other providers receive from CCOs. In sum, to have an allowance reviewed for reasonableness, a provider group must demonstrate to the Commissioner's satisfaction that the allowance under the Medicare fee schedule is more than 10% lower than the average level of reimbursement that provider specialty receives from the private managed care market, and such an allowance will not be found to be unreasonable unless that provider group can clearly demonstrate to the Commissioner's satisfaction through sufficient credible data that this disparity is substantially disproportionate to existing disparities in the allowances for other providers between the Workers' Compensation and private managed care markets.

Pre-exposure comments from the Insurance Federation of Pennsylvania, Inc. ("IFP") and the Department of Labor and Industry ("L&I") were taken into consideration in the drafting of this proposed rulemaking.

Explanation of Regulatory Changes

In August of 1995, the Pennsylvania Society of Anesthesiologists ("PSA") filed a petition with the Department seeking to have the Department review the Workers' Compensation anesthesia conversion factor for reasonableness and, ultimately, to have the anesthesia conversion factor adjusted through the issuance of a regulation. The anesthesia conversion factor is an integral part of the formula under which surgical anesthesia services are reimbursed, typically multiplied by a time factor (number of units) and sometimes by other factors to determine compensation for an anesthesia procedure under the Workers' Compensation system.

Over the course of the past eight years, PSA submitted substantial amounts of data, including expert reports, and through counsel, participated in a multitude of meetings with the Department in order to carry its initial burden of having the anesthesia conversion factor reviewed for reasonableness and to ultimately carry its burden of persuasion to convince the Department that this allowance for anesthesia services was unreasonable. Although the information and data submitted to the Department is confidential under the statute, counsel for PSA has agreed to provide an aggregate summary of the data upon request.

Based on the extensive, credible, and persuasive nature of the data and expert reports submitted by PSA, the Department eventually concluded that PSA had met the standard required to have the anesthesia conversion factor reviewed for reasonableness. After an extensive and lengthy review process, the Department ultimately determined, based on the quantity and quality of the data presented, that the anesthesia conversion factor under Workers' Compensation was not reasonable in light of the fact that the disparity between anesthesia allowances under the Workers' Compensation and private managed care systems was substantially and patently disproportionate to disparities for other providers.

Among the data and materials considered by the Department in reaching this conclusion were four reports submitted by PSA providing data and analysis in support of its assertion that the Workers' Compensation allowance for anesthesiologists is not reasonable compared to allowances for other medical specialties. The four Reports are:

- *Survey Of Anesthesia Reimbursement By Private Managed Care Payors And Comparison To Workers' Compensation Reimbursement* (January, 2001);

- *Reimbursement By HMOs And Comparison To Workers' Compensation Reimbursement For Specialties Other Than Anesthesia* (September 2001);

- *Letter of August 26, 2002, from PSA counsel providing data on reimbursement for non-surgical procedures*; and

- *A Comparison Of Reimbursement To Anesthesiologists And Other Medical Specialties Under Pennsylvania's Workers' Compensation Program And Private Market Fee Schedules*, prepared by Dennis Olmstead Chief Economist & Vice President of the Division of Practice Economics & Payer Relations for the Pennsylvania Medical Society (June, 2003).

In explaining the Department's decision, it is helpful to discuss the four Reports individually.

1. Survey Of Anesthesia Reimbursement By Private Managed Care Payors And Comparison To Workers' Compensation Reimbursement (January, 2001).

This Report focused solely on reimbursements received by anesthesiologists under Workers' Compensation and from managed care payors, looking at actual claims. The Report included data from all four Workers' Compensation regions, for 27 different payors, from 12 anesthesia practices. 139 claims were reviewed and more than 55 distinct anesthesia conversion factors (by payor and practice) were identified. Only 2 of those 55 distinct conversion factors were less than that used in Workers' Compensation and both were from a single payor, a Medicaid HMO.

The data showed that Workers' Compensation was reimbursing anesthesiologists at about 50% of the level of most managed care payors. The overwhelming predominance of managed care conversion factors were between $30 and $55 and, within that, between $35 and $45, at a time when Worker's Compensation conversion factors ranged from $19.55 to $21.72. Based on this Report, the Department concluded that reimbursement to anesthesiologists satisfied the first

statutory criteria—specifically, that the allowance be at least 10% less than the private managed care market—and that PSA had met the required burden in order to have the allowance reviewed for reasonableness. Certain of the other Reports subsequently submitted, while they focused on reimbursements received by other specialties under Workers' Compensation and from managed care payors, contained some additional (and consistent) data on reimbursement to anesthesiologists.

2. Reimbursement By HMOs And Comparison To Workers' Compensation Reimbursement For Specialties Other Than Anesthesia (September 2001).

This Report analyzed claims data on 666 "CPT Code data points"; for four specialties—namely, cardiology, general surgery, ophthalmology, and orthopedics; in three of the four Workers' Compensation Regions; with data from 11 managed care payors, including the major payors in all areas. A "CPT Code data point" is reimbursement of a CPT code to a distinct provider by a distinct payor. The results for the non-anesthesia specialties were virtually the mirror image of the results for anesthesiologists. While the Workers' Compensation anesthesia conversion was about 50% lower than the common range of private managed care rates (around $35-$45), Workers' Compensation was consistently higher, with a range around 50% higher, than the private managed care rates for the four specialties. The data was consistent in every respect among those specialties and entirely inconsistent with the anesthesia data, as the table below summarizes, by region and across specialties.

	# of CPT Code data points for which Workers' Compensation allowance > HMO reimbursement/total # of data points		Average % Workers' Compensation > HMO reimbursement
REGION 1			
Cardiology	110/133	82.7%	145.97%
General Surgery	62/67	92.5%	165.86%
Ophthalmology	78/103	75.7%	127.49%
Orthopedics	127/144	88.79%	128.15%
Region 1 Summary	377/447	83.4%	141.87%
REGION 2			
Cardiology	46/47	97.87%	152.89%
Ophthalmology	32/37	86.48%	159.70%
Region 2 Summary	78/84	92.86	156.30
REGION 3			
Cardiology	44/50	88%	198.68%
General Surgery	20/21	95.2%	155.42%
Ophthalmology	18/21	85.7%	158.63%

Orthopedics	40/43	93.02%	190.20%
Regional Summary	122/135	90.37%	175.73%

The column entitled "Average %, Workers' Comp. v. All Claims" is calculated for a specialty within a region by summing the percentages from all pertinent claims and dividing by the total number of inputs. The lowest average percentage (by region and specialty) by which Workers' Compensation payments exceeded managed care payments was 28.15% (orthopedics, Region I), while the highest was 98.68% (cardiology, Region III). There were some CPT Code data points (89 out of 666 or 13.4%) for which the managed care rates exceeded Workers' Compensation allowances by 200% to 400%, and a comparable number (99 out of 666 or 14.86%) in which Workers' Compensation allowances exceed managed care rates by 400% or more. For the overwhelming majority of CPT Code data points, however, the ratio of Workers' Compensation allowances to managed care rates fell between 100% and 200% (478 out of 666 or 71.7%).

3. Letter of August 26, 2002 from PSA counsel providing data on reimbursement for non-surgical procedures.

At the Department's request, PSA supplemented its analysis of the data it obtained for the second Report to examine non-surgical procedures and non-procedures. This included various Evaluation and Management Codes ("E&M Codes"), both generally and as to ophthalmology and cardiology, and pathology and radiology. The results were consistent with those for the four specialties reviewed in the second Report. Workers' Compensation paid slightly more than 10% more than the HMOs for all E&M codes at one large provider system and 58% more at another; approximately 22% more than the HMOs for E&M services provided by ophthalmologists and 11% more than the HMOs for E&M services provided by cardiologists. Regarding radiology, Workers' Compensation paid approximately 45% more than the HMOs, using data from "chest codes" and those for Diagnostic Ultrasound, head & neck. Analyzing data from the 6 basic pathology codes, 88300-88309, from all 3 major HMOs, Workers' Compensation paid approximately 50% more than the HMOs. E&M, radiology, and pathology were also looked at in the fourth study, discussed immediately below, with consistent results. This data established that Worker's Compensation payments consistently exceed payments of other payors for 2 additional "non-surgical" specialties (radiology and pathology) as well as all medical specialties that rely heavily on E & M codes.

4. A Comparison Of Reimbursement To Anesthesiologists And Other Medical Specialties Under Workers' Compensation And Private Market Fee Schedules.

This Report compared reimbursements to anesthesiologists, radiologists, pathologists, E&M Codes, surgery in general, and the surgical specialties of dermatology, ENT gastroenterology and OB-GYN for 86 heavily utilized CPT Codes (surgery - 44 codes; radiology - 20 codes; pathology - 12 codes; and E&M - 10 codes). The Report compared Workers' Compensation reimbursements for these specialties with those of three Highmark fee schedules – the 5000S (poverty level fee schedule), UCR, and Keystone Health Plan West ("KHPW"). 5000S is not a managed care plan but was included because it is a plan available only to persons whose incomes fall within established limitations and, as a consequence, has among the lowest reimbursement levels of Highmark fee schedules. KHPW is a managed care network operated by Highmark that serves 29 counties in Western Pennsylvania (Workers' Compensation Region II) and is the largest HMO in those counties by market share. The UCR schedule is also a non-managed care system and is considered to have relatively higher reimbursements.

The results confirmed the results of the first Report that Workers' Compensation reimbursement to anesthesiologists was substantially less than that of managed care payors. The following chart summarizes the data with respect to anesthesiologists:

	Region 1	Region II	Region III	Region IV	Average
Workers' Comp.	$23.98	$23.83	$22.93	$21.37	$23.03
5000S	$37	$37	$37	$37	$37
KHPW		$42			
UCR	$42	$42	$42	$42	$42
% Difference, WC & 5000S	(35.2%)	(35.6%)	(38%)	(42.2%)	(37.8%)
% Difference, WC & KHPW		(43.3%)			
% Difference, WC & UCR	(42.9%)	(43.3%)	(45.4%)	(49.1%)	(45.2%)

Even the 5000S low income fee schedule reimbursed anesthesiologists substantially better than did Workers' Compensation. KHPW'S reimbursement was approximately 43% greater ($42 vs. $23.83) than Workers' Compensation.

The findings as to non-anesthesia specialties, including those performing surgery, those being reimbursed under E&M Codes, and those (pathologists and radiologists) who primarily perform non-surgical procedures were entirely consistent with the findings of the 2nd and 3rd Reports. Almost without exception, Workers' Compensation reimbursed those physician specialties at levels above the managed care rates. Specifically, Workers' Compensation on average paid 41.9% more than the KHPW fee schedule for non-anesthesia Codes in Workers' Compensation Region II; 74.8% and 60.5% greater than the 5000S fee schedule in Regions I and IV, respectively; and 47.1% and 35% greater than the UCR rate in Regions I and IV, respectively.

To summarize the above, in reviewing PSA's initial petition and conducting its ultimate review, the Department considered data that included major HMOs; numerous codes for non-anesthesia specialties (cardiology, orthopedics, ophthalmology, and surgery); surgical specialties (general surgery, ENT, dermatology, and OB-GYN); non-surgical procedures (pathology and radiology) and evaluative care (E&M). The data was very consistent from specialty to specialty and region-to-region in showing a consistent relationship between Workers' Compensation and managed care payors – Workers' Compensation is the better payor – with the sole exception of anesthesiology, in which the relationship between payors is essentially reversed. While the Workers' Compensation anesthesia conversion factor was about 50% lower than the common range of private managed care rates (clustering between $35-$45 at a time when Worker's Compensation conversion factors ranged from $19.55 to $21.72.), Workers' Compensation was consistently higher, with a range around 50% higher, than the private managed care rates for the other four specialties.

Based on the data, the Department has concluded that:

The Workers' Compensation Program reimburses anesthesiologists at a rate that is substantially below the rates of managed care payors throughout Pennsylvania.

This substantial disparity does not exist with respect to other specialties. In general, Workers' Compensation reimbursement to these specialties exceeds the payments in managed care, often by substantial amounts. This includes surgical specialties, non-surgical specialties, and evaluation and management codes that are used by surgical and non-surgical specialists alike (although generally excluding anesthesiologists).

Accordingly, the Department determined that the standards of Subsection 306(f.1)(3)(i) have been met with respect to the anesthesia conversion factor. As such, the Department is proposing to adopt the regulation as set forth in Annex A establishing a new allowance for the anesthesia conversion factor for use in the Workers' Compensation Program.

Fiscal Impact

There is minimal fiscal impact as a result of the proposed rulemaking. There is no specific data available identifying the precise costs associated with the cost of anesthesiology benefits under the workers compensations system. However, it is known that the expenses resulting from medical benefits are approximately 45% of total loss expenses. In addition, the loss expenses resulting from anesthesiology is a minor cost in comparison to the total costs of surgical expenses. Therefore even though the regulation will increase the reimbursement of anesthesiology expenses by 63%, it should affect the overall costs only minimally.

Paperwork

There is no anticipated additional paperwork expected as a result of this proposed rulemaking.

Affected Parties

The proposed rulemaking will affect all anesthesiologists who provide anesthesia services to persons whose care is reimbursed under the Workers' Compensation Program when the anesthesia conversion factor is a basis for reimbursement. It will also affect all insurers and others who directly or indirectly assume responsibility for the costs of medical care provided under the Workers' Compensation Program

Effectiveness/Sunset Date

The rulemaking will become effective upon final adoption and publication in the *Pennsylvania Bulletin* as final-form rulemaking. The Department continues to monitor the effectiveness of regulations on a triennial basis; therefore, no sunset date has been assigned.

Contact Person

Questions or comments regarding the proposed rulemaking may be addressed in writing to Peter J. Salvatore, Regulatory Coordinator, Insurance Department, 1326 Strawberry Square, Harrisburg, PA 17120, within 30 days following the publication of this notice in the *Pennsylvania Bulletin*. Questions and comments may also be e-mailed to *psalvatore@state.pa.us* or faxed to (717) 772-1969.

Under the Regulatory Review Act, the Department is required to write to all commentators requesting whether or not they wish to receive a copy of the final-form rulemaking. To better serve stakeholders, the Department has made a determination that all commentators will receive

a copy of the final-form rulemaking when it is made available to the Independent Regulatory Review Commission (IRRC) and the Legislative Standing Committees.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P.S. § 745.5(a)), on June 16, 2004, the Department submitted a copy of this proposed rulemaking to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the Senate Banking and Insurance Committee and the House Insurance Committee. In addition to the submitted proposed rulemaking, the Department has, as required by the Regulatory Review Act, provided IRRC and the Committees with a copy of a detailed Regulatory Analysis Form prepared by the Department. A copy of that material is available to the public upon request.

IRRC will notify the Department of any objections to any portion of the proposed rulemaking within 30 days of the close of the public comment period. The notification shall specify the regulatory review criteria that have not been met by that portion. The Regulatory Review Act specifies detailed procedures for the Department, the Governor, and the General Assembly to review these objections before final publication of the regulations.

M. DIANE KOKEN,
Insurance Commissioner

Annex A

TITLE 31. INSURANCE. PART VIII. MISCELLANEOUS PROVISIONS. CHAPTER 167. Workers' Compensation Act-Provider Fees.

Sec.

§ 167.1. Purpose.

The purpose of this section is to set the allowance for anesthesia services provided to patients under the Pennsylvania Workers' Compensation Act when the allowance utilizes the anesthesia conversion factor.

§ 167.2. Payment for Anesthesia Services.

The Workers' Compensation Part B Fee Schedule shall be amended by multiplying the anesthesia conversion factor applicable to Codes 100-1999 by a multiplier of 1.632. The Fee Schedule, as amended, shall apply to anesthesia services provided in all regions after the effective date of this regulation.

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
SPECIAL PROJECTS OFFICE
1326 Strawberry Square
Harrisburg, PA 17120

Phone: (717) 787-4429
Fax: (717) 772-1969
E-mail: psalvatore@state.pa.us

June 16, 2004

Mr. Robert Nyce
Executive Director
Independent Regulatory Review Comm.
333 Market Street
Harrisburg, PA 17101

Re: Insurance Department Proposed Regulation No. 11-222, Workers' Compensation Act – Provider Fees

Dear Mr. Nyce:

Pursuant to Section 5(a) of the Regulatory Review Act, enclosed for your information and review is proposed regulation 31 Pa. Code, Chapter 167.

The purpose of this proposed rulemaking is to adopt Chapter 167 setting the allowance for anesthesia services provided to patients under the Pennsylvania Workers' Compensation Act when the allowance utilizes the anesthesia conversion factor.

The rate established by Section 167.2 shall be used for the period from the effective date of this regulation and updated annually thereafter in accordance with the provisions of 34 Pa. Code §127.162 and Section 306(f.1)(3)(ii) of the Pennsylvania Workers' Compensation Act (77 P.S. §531(3)(ii)).

If you have any questions regarding this matter, please contact me at (717) 787-4429.

Sincerely yours,

Peter J. Salvatore
Regulatory Coordinator

11-222p.doc

TRANSMITTAL SHEET FOR REGULATIONS SUBJECT TO THE REGULATORY REVIEW ACT

I.D. NUMBER:	11-222
SUBJECT:	Workers' Compensation Act - Provider Fees
AGENCY:	DEPARTMENT OF INSURANCE

TYPE OF REGULATION

X Proposed Regulation

Final Regulation

Final Regulation with Notice of Proposed Rulemaking Omitted

120-day Emergency Certification of the Attorney General

120-day Emergency Certification of the Governor

Delivery of Tolled Regulation
a. With Revisions b. Without Revisions

FILING OF REGULATION

DATE	SIGNATURE	DESIGNATION
6/14/04		HOUSE COMMITTEE ON INSURANCE
6/16/04		
6-16-04		SENATE COMMITTEE ON BANKING & INSURANCE
6/16/04		
6/16/04		INDEPENDENT REGULATORY REVIEW COMMISSION
		ATTORNEY GENERAL (for Final Omitted only)
6/16/04		LEGISLATIVE REFERENCE BUREAU (for Proposed only)

June 14, 2004