Regulatory Analysis Form

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INDEPENDENT REGULATORY REVIEW COMMISSION

(1) Agency

Department of Labor and Industry
Bureau of Workers' Compensation

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

12-72

IRRC Number: 2542

(3) Short Title

Medical Cost Containment

(4) PA Code Cite

34 Pa. Code Chapter 127

(5) Agency Contacts & Telephone Numbers

Primary Contact: Eileen Wunsch, Chief, Health Care Services Review Division; (717) 772-1912
Secondary Contact: John T. Kupchinsky, Director, Bureau of Workers' Compensation; 717-783-5421

(6) Type of Rulemaking (check one)

X Proposed Rulemaking
Final Order Adopting Regulation
Final Order, Proposed Rulemaking Omitted

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

X No
Yes: By the Attorney General
Yes: By the Governor

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

The Department of Labor and Industry (Department), Bureau of Workers' Compensation (Bureau), proposes the following amendments to Chapter 127 of Title 34 of the Pennsylvania Code (Medical Cost Containment Regulations) to provide and clarify requirements and procedures for reimbursement and review of medical treatment for work-related injuries under the Pennsylvania Workers' Compensation Act (Act), 77 P.S. §§ 1 – 2626.

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

The Department proposes these amendments to the Medical Cost Containment Regulations under the authority contained in sections 306(f.2), 401.1, 420(a) and 435 of the Act (77 P.S. §§ 53, 710, 831 and 991).

(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 federal law or court order requires the Department to adopt this regulation. However, section 306 of the Act, 77 P.S. § 531.1, contemplates the promulgation of regulations for the purposes of utilization review and the medical benefits fee schedule.

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

Since 1995, the Department had the opportunity to examine the current rules' operation and effectiveness. Myriad issues and occurrences, including far-reaching changes to Medicare payment systems and the advent of new medical procedures, have arisen during the Department's administration of the current regulations, and have diminished the effectiveness and applicability of the Medical Cost Containment Regulations to the current workers' compensation and medical environments. Additionally, members of the regulated communities have alerted the Department to potential inefficiencies in the existing regulations. These are all compelling reasons for the Department to propose this rulemaking.

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

Nonregulation would lead to growing inconsistencies between the current rule and contemporary medical standards and technologies, as well as medical billing procedures.

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

Employees, employers, workers' compensation insurers and the Bureau will benefit from these regulations. The proposed regulations will increase the efficiency and effectiveness of the parties' transactions with the Bureau and each other. The proposed regulations will simplify many aspects of the provision and payment of medical benefits under the Act, and will provide additional certainty to virtually all aspects of medical treatment under the Act.

(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.)

No one will be adversely affected by the regulations.

(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 following persons, groups or entities will be required to comply with the regulations: approximately 300 workers' compensation insurers, including the State Workers' Insurance Fund; approximately 800 self-insured employers, including the Commonwealth; workers' compensation judges; Workers' Compensation Appeals Board commissioners and officials; employees of the Department; and participants in the Pennsylvania workers' compensation system, including injured employees, health care providers, employers, workers' compensation insurers and their respective counsel.

(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.

On September 16, 2004, the Department held a stakeholder meeting to discuss issues and solutions regarding the Medical Cost Containment Regulations. The following groups were invited:

PA Chapter of IARPS; Office of Vocational Rehabilitation, PA Rehabilitation Counseling Association; American Insurance Association; Alliance of American Insurers; Pennsylvania Trial Lawyers Association; PBA Workers' Compensation Law Section, Martin, Banks, Pond, Lehocky & Wilson; PBA WC Liaison Committee; Spence, Custer, Saylor, Wolfe & Rose; Insurance Federation of Pennsylvania, Inc.; Pennsylvania Self-Insurance Association; Thomas Jefferson University Hospital; PA Defense Institute Workers' Compensation Committee; Pennsylvania AFL-CIO; Commission on Rehabilitation Counselor Certification; Alico Services, Ltd.; American Review Systems, Inc.; C.A.B. Medical Consultants; CEC, Inc.; CorVel Corporation; First Managed Care Option; Hajduk & Associates; Health Care Dimensions, Inc.; Industrial Rehabilitation Association, c/o FJP Enterprises, Inc.; KVS Consulting Services; LRC Rehabilitation Consultants; McBride & McBride Associates; QRS Managed Care Services; Quality Assurance Reviews, Inc.; Rehabilitation Planning, Inc.; Solomon Associates, Inc.; T&G Reviews; Tx Review Inc.; West Penn IME, Inc.; AIG Claim Services, Inc.; American Interstate Insurance Company; CAN Insurance Company; CompServices, Inc.; Donegal Mutual Insurance Company; Eckert Seamans; Erie Insurance Company; Guard Insurance Group; Jonathan Greer; Liberty Mutual Insurance Company; Exelon Corporation; Penn National Insurance; PMA Group; Peerless Insurance; Risk Management, Inc.; State Workers' Insurance Fund; St. Paul Travelers Insurance

Company; Zurich North America; Hospital Association of PA; Temple University Hospital; David Frank, M.D.; PPTA; Northeastern Rehab. Assoc.; PA Association of Rehab Facilities; Paul Goble; PA Chiropractic Association; The Hetrick Center; Dr. Carl Hiller; Dr. Walter Engle; Catherine Wilson, Pennsylvania Medical Society; Dr. Roy Lefkoe, Dr. Jon B. Tucker, PA Orthopedic Society; PA Pharmacists Association; Milton S. Hershey Medical Center; PA Insurance Department; Larry Chaban, Esquire.

Additionally, as a result of the invitation to the September 16, 2004 meeting, the Department received written comments from the following groups: the Pennsylvania Chiropractic Association; the State Workers' Insurance Fund; The Hospital and Healthsystem Association of Pennsylvania; the Pennsylvania AFL/CIO; the Pennsylvania Medical Society; the Pennsylvania Trial Lawyers Association; the Pennsylvania Orthopedic Society; the PMA Insurance Group; LRC Rehabilitation Associates, Inc.; the American Insurance Association; the Insurance Federation of Pennsylvania; Hajduk & Associates; Compservices, Inc.; and, the Department's Office of Adjudication.

Actual attendees who provided comments at the meeting were: Kenneth Stoller, of the American Insurance Association; David Wilderman and Ronald Calhoon, of the Pennsylvania AFL/CIO; Sam Marshall, of the Insurance Federation of Pennsylvania; Jerry Lehocky, of the Pennsylvania Trial Lawyers Association; Dr. Maria Hatam, of the PMA Group; and, Leona Franks, of LRC Rehabilitation Consultants, Inc.

(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.

No significant costs are anticipated. Obtaining or creating the new form, the Request for Pre-certification of Treatment, may be an insignificant cost to employers and insurers and will present little or no cost to employees or the Bureau. The regulated community will likely benefit from the ease of administration and additional certainty provided by the regulations, but such benefits are not readily quantifiable.

(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.

No significant costs are anticipated. To the extent that local governments are employers, obtaining or creating the new form, the Request for Pre-certification of Treatment, may be an insignificant cost. The regulated community will likely benefit from the ease of administration and additional certainty provided by the regulations, but such benefits are not readily quantifiable.

(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.

No significant costs are anticipated. To the extent that the Commonwealth is an employer, obtaining or creating the new form, the Request for Pre-certification of Treatment, may be an insignificant cost. The regulated community, including the Commonwealth as an employer, will likely benefit from the ease of administration and additional certainty provided by the regulations. However, these benefits are not readily quantifiable.

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(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.

	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						
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.

There are no means to estimate any slight cost associated with the regulation.

Regulatory Analysis Form

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

Program	FY -3	FY -2	FY -1	Current FY
Workers' Comp. Administration Fund	$ 51,422,033.00	$ 52,551,198.00	$ 49,441,420.00 (as of 8/5/04; closing in 10/04)	$ 55,000,000.00 (appropriation for year)
Non-BWC programs that may be impacted	Unquantifiable	Unquantifiable	Unquantifiable	Unquantifiable

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

There are no adverse effects and costs. Instead, the proposed regulations would greatly simplify and add certainty to the workers' compensation system, while further protecting the health and welfare of injured employees throughout the Commonwealth.

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

Non-regulatory alternatives cannot create a legally-enforceable standard and therefore were not considered. These regulations provide updated information and guidance to an already existing act and regulations.

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

Alternative regulatory schemes were not considered because amending the current regulations is the only appropriate means to incorporate these updated standards and procedures.

(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.

There are no comparable federal standards.

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

Comparison to other states' provisions is impractical because statutory requirements and systems differ from state to state. However, the proposed regulations are likely to enhance the Commonwealth's competitive advantage by providing a business climate designed to promote economic growth, while protecting the health and welfare of Pennsylvania's employees.

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

These regulations will amend 34 Pa. Code Chapter 127 (relating to medical cost containment) by updating and clarifying the existing regulations that govern the administration of the Act and related procedures.

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

It is not anticipated that any other meetings will be scheduled prior to consideration of the proposed rulemaking, except those required by the Independent Regulatory Review Act, or as otherwise ordered by the Independent Regulatory Review Commission. The Department does plan to conduct informational meeting during consideration, and after approval of final-form rulemaking.

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 proposed regulations require the creation of only one new form, the Request for Pre-certification of Treatment. Existing forms require few modifications. Therefore, the proposed regulations do not impose any significant additional reporting, record keeping or paperwork requirements on either the Commonwealth or the regulated community.

(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.

There is no need for special provisions.

(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 proposed regulations will be effective when published in the *Pennsylvania Bulletin* as final-form regulations. These regulations will require no new licenses, permits or approvals.

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

The Department will continue to monitor the impact and effectiveness of the regulations. Changes to the Act and court decisions may lead to amendment of the regulations.

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INDEPENDENT REGULATORY REVIEW COMMISSION

FACE SHEET
FOR FILING DOCUMENTS
WITH THE LEGISLATIVE REFERENCE BUREAU

(Pursuant to Commonwealth Documents Law)

#2542

Copy below is hereby approved as to form and legality. Attorney General

DEPUTY ATTORNEY GENERAL

MAY 15 2006

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:

Department of Labor & Industry
(AGENCY)

DOCUMENT / FISCAL NOTE NO. 12-72

DATE OF ADOPTION:

BY: Stephen M. Schmerin

TITLE: Secretary
(EXECUTIVE OFFICER, CHAIRMAN OR SECRETARY)

Copy below is hereby approved as to form and legality. Executive or Independent Agencies.

BY: ANDREW C. CLARK

APR 21 2006

DATE OF APPROVAL

Executive Deputy General Counsel

___ Check if applicable. No Attorney General approval or objection within 30 days after submission.

PROPOSED RULEMAKING

Title 34. LABOR AND INDUSTRY

DEPARTMENT OF LABOR AND INDUSTRY
[34 PA. CODE CH. 127]

MEDICAL COST CONTAINMENT

PROPOSED RULEMAKING
Title 34-Labor and Industry
Part VIII
Chapter 127
[34 Pa. Code Chapter 127]

The Department of Labor and Industry (Department), Bureau of Workers' Compensation (Bureau), proposes the following amendments to Chapter 127 of Title 34 of the Pennsylvania Code (the Medical Cost Containment Regulations) to provide and clarify requirements and procedures for reimbursement and review of medical treatment for work-related injuries under the Pennsylvania Workers' Compensation Act (Act).

Statutory Authority

The Department proposes these amendments to the Medical Cost Containment Regulations under the authority contained in sections 306(f.1), 401.1, 420(a) and 435 of the Workers' Compensation Act (Act) (77 P.S. §§ 531, 710, 831 and 991).

Background

The Medical Cost Containment Regulations were originally promulgated on November 11, 1995 in response to the enactment of Act 44 of 1993 (Act 44). Act 44 amended the Act to provide medical cost containment mechanisms, including medical fee caps, fee review procedures, designated lists of physicians, and medical treatment review procedures. The regulations were further amended on January 17, 1998, in response to the enactment of Act 57 of 1996, which significantly altered the Regulations' utilization review and designated list of physicians provisions.

Since 1995, the Department has had the opportunity to examine the Regulations' operation and effectiveness. Myriad issues and occurrences, including far-reaching changes to Medicare payment systems and the advent of new medical procedures, arose during the Department's administration of the Regulations and have diminished the effectiveness and applicability of the regulations to the current workers' compensation and medical environments. Additionally, members of the regulated communities have alerted the Department to potential inefficiencies in the existing regulations, which the Department proposes to remedy through this rulemaking.

On September 16, 2004, the Department held a stakeholder meeting to discuss this proposed rulemaking and invited the following groups: PA Chapter of IARPS; Office of Vocational Rehabilitation, PA Rehabilitation Counseling Association; American Insurance Association; Alliance of American Insurers; Pennsylvania Trial Lawyers Association; PBA Workers' Compensation Law Section, Martin, Banks, Pond, Lehocky & Wilson; PBA WC Liaison Committee; Spence, Custer, Saylor, Wolfe & Rose; Insurance Federation of Pennsylvania, Inc.; Pennsylvania Self-Insurance Association; Thomas Jefferson University Hospital; PA Defense Institute Workers' Compensation Committee; Pennsylvania AFL-CIO; Commission on Rehabilitation Counselor Certification; Alico Services, Ltd.; American Review Systems, Inc.; C.A.B. Medical Con-

sultants; CEC, Inc.; CorVel Corporation; First Managed Care Option; Hajduk & Associates; Health Care Dimensions, Inc.; Industrial Rehabilitation Association, C/O FJP Enterprises, Inc.; KVS Consulting Services; LRC Rehabilitation Consultants; McBride & McBride Associates; QRS Managed Care Services; Quality Assurance Reviews, Inc.; Rehabilitation Planning, Inc.; Solomon Associates, Inc.; T&G Reviews; Tx Review Inc.; West Penn IME, Inc.; AIG Claim Services, Inc.; American Interstate Insurance Company; CAN Insurance Company; CompServices, Inc.; Donegal Mutual Insurance Company; Eckert Seamans; Erie Insurance Company; Guard Insurance Group; Jonathan Greer; Liberty Mutual Insurance Company; Exelon Corporation; Penn National Insurance; PMA Group; Peerless Insurance; Risk Management, Inc.; State Workers' Insurance Fund; St. Paul Travelers Insurance Company; Zurich North America; Hospital Association of PA; Temple University Hospital; David Frank, M.D.; PPTA; Northeastern Rehab. Assoc.; PA Association of Rehab Facilities; Paul Goble; PA Chiropractic Association; The Hetrick Center; Dr. Carl Hiller; Dr. Walter Engle; Pennsylvania Medical Society; Catherine Wilson; PA Orthopedic Society; Dr. Roy Lefkoe; Dr. Jon B. Tucker; PA Pharmacists Association; Milton S. Hershey Medical Center; PA Insurance Department; Larry Chaban, Esquire

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Actual attendees who made presentations at the meeting were: Kenneth Stoller, of the American Insurance Association; David Wilderman and Ronald Calhoon, of the Pennsylvania AFL/CIO; Sam Marshall, of the Insurance Federation of Pennsylvania; Jerry Lehocky, of the Pennsylvania Trial Lawyers Association; Dr. Maria Hatam, of the PMA Group; and Leona Franks, of LRC Rehabilitation Consultants, Inc.

All comments and suggestions have been reviewed and considered.

Purpose

By this proposed rulemaking, the Department seeks to address and correct uncertainties, competing interpretations, and administrative obstacles encountered during the administration of the Regulations. Further, the Department intends to remedy inefficiencies in the Medical Cost Containment system and to update terminology and processes used and described in the regulations to better reflect current practices, procedures and definitions.

Summary of Proposed Rulemaking

Chapter 127. Workers' Compensation Medical Cost Containment

Subchapter A. Preliminary Provisions

The Department proposes amending § 127.2 (relating to filing and service -- computation of time) to promote consistency in filing and service requirements and to coordinate filing and service practices under all chapters of the Bureau of Workers' Compensation's regulations.

The Department proposes amending § 127.3 (relating to definitions) to ensure that terminology utilized in the regulations is consistent with the terminology utilized in the health care and insurance industries. Further, the Department proposes amending this section to provide additional and updated definitions as necessary to reflect amendments made throughout the regulations.

Subchapter B. Medical Fees and Fee Review

Throughout this chapter, references to the Secretary of Health's approval of Coordinated Care Organizations (CCOs) have been amended to reflect that CCOs are approved by the Department. Additionally, numerous provisions have been amended to clarify that rates for services under the fee schedule were capped upon implementation of the fee schedule, and are updated pursuant to §§ 127.151 - 127.162. Further, the Department has made amendments throughout this subchapter to specifically identify those provisions that supersede the General Rules of Administrative Practice and Procedure, 1 Pa. Code Part II (GRAPP). Finally, changes in grammar, punctuation and terminology appear throughout this subchapter.

In addition, the Department proposes amending § 127.103 (relating to outpatient providers subject to the Medicare fee schedule – generally) to remove the reference to the "transition fee schedule." This reference is no longer necessary in light of changes in the Medicare system and the establishment of the original workers' compensation fee schedule. The Department further proposes amendments to clarify the means of updating outpatient providers' reimbursement rates.

The Department proposes amending § 127.104 (relating to outpatient providers subject to the Medicare fee schedule – physicians) to clarify the means of updating physicians' reimbursement rates.

The Department proposes amending § 127.105 (relating to outpatient providers subject to the Medicare fee schedule – chiropractors) to remove references to specific HCPCS codes, and instead require billing based upon the appropriate codes. This amendment ensures that services rendered by chiropractors will be billed according to the correct codes regardless of changes to the coding system. The Department further proposes amendments to clarify the means of updating chiropractors' reimbursement rates.

The Department proposes amending § 127.106 (relating to outpatient providers subject to the Medicare fee schedule – spinal manipulation performed by doctors of osteopathic medicine) to remove references to specific HCPCS codes, and instead require billing based upon the appro-

priate codes. This amendment ensures that services rendered by doctors of osteopathic medicine will be billed according to the correct codes regardless of changes to the coding system. The Department further proposes amendments to clarify the means of updating osteopathic doctors' reimbursement rates.

The Department proposes amending § 127.107 (relating to outpatient providers subject to the Medicare fee schedule – physical therapy centers and independent physical therapists) to clarify the means of updating physical therapy centers' and physical therapists' reimbursement rates.

The Department proposes amending § 127.108 (relating to durable medical equipment and home infusion therapy) to clarify the means of updating reimbursement rates applicable to durable medical equipment and home infusion therapy.

The Department proposes amending § 127.109 (relating to supplies and services not covered by fee schedule) to require that providers specifically identify supplies provided under this section.

The Department proposes amending §§ 127.110 (relating to inpatient acute care providers – generally) and 127.111 (relating to inpatient acute care providers – DRG payments) to clarify that updates to DRG calculations are found in § 127.111a (relating to inpatient acute care providers – DRG updates).

The Department proposes adding § 127.111a (relating to inpatient acute care providers – DRG updates) to provide that the DRG grouper components in effect on the date of discharge shall be used to calculate reimbursement. The Department further proposes amendments to clarify the means of calculating and updating payments to inpatient acute care providers.

The Department proposes amending § 127.114 (relating to inpatient acute care providers – outliers) to clarify that the applicable Medicare cost threshold is $36,000.

The Department proposes amending § 127.117 (relating to outpatient acute care providers, specialty hospitals and other cost-reimbursed providers) to clarify the means for updating reimbursement rates under this section. In addition, the Department proposes amending the means of identifying services in the charge master, by reference to service descriptors instead of service codes. Further, the Department proposes amending this section to provide the means for incorporating new codes and new services under this section. Finally, the Department proposes amending this section to provide that providers that, after the effective date of the amendment, add new services for which Medicare reimburses on a fee-for-service basis will be reimbursed under this section on a fee-for-service basis.

The Department proposes amending §§ 127.120 (relating to RCCs – comprehensive outpatient rehabilitation facilities (CORFS) and outpatient physical therapy centers); 127.121 (relating to cost-reimbursed providers – medical education costs); 127.122 (relating to skilled nursing facilities); 127.123 (relating to hospital-based and freestanding home health care providers); and

127.124 (relating to outpatient and end-stage renal dialysis payment) to clarify the means of updating reimbursement rates for these services and providers.

The Department proposes amending § 127.125 (relating to ASCs) to provide that reimbursement to facilities operating as Ambulatory Surgical Centers (ASCs) will be based upon Medicare's ASC rates where the ASC is licensed by the Pennsylvania Department of Health, and to further clarify the means of updating reimbursement rates under this section.

The Department proposes amending § 127.128 (relating to trauma centers and burn facilities – exemption from fee caps) to provide that trauma centers and burn facilities continue to receive their usual and customary charges.

The Department proposes amending § 127.129 (relating to out-of-state medical treatment) to eliminate the requirement that out-of-state providers cap fees based upon the Pennsylvania fee schedule. This requirement has proven to be unenforceable, and has provided false assurance to individuals seeking treatment from out-of-state providers who often seek to "balance-bill" injured employees.

The Department proposes amending § 127.130 (relating to special reports) to remove reference to the particular CPT code applicable to "special reports," because the code may change over time. The Department further proposes removing the requirement that payment for these reports be capped at 80% of usual and customary charges, because special reports are not generally a component of medical treatment and, by definition, provide greater information than required under the Act.

The Department proposes amending § 127.131 (relating to payments for prescription drugs and pharmaceuticals – generally) to provide that the Bureau will refer to the "Drug Topics Redbook" when resolving fee disputes involving prescription drugs and pharmaceuticals.

The Department proposes amending § 127.132 (relating to payments for prescription drugs and pharmaceuticals – direct payment) to clarify that insurers may limit reimbursement/payment to pharmacies appearing on a proper list of designated providers, as set forth in subchapter D (relating to employer list of designated providers). The Department proposes this clarification to better reflect the current state of the law regarding prescription reimbursement and designated providers.

The Department proposes amending § 127.133 (relating to payments for prescription drugs and pharmaceuticals – effect of denial of coverage by insurers) to provide that insurers must reimburse employees for the actual costs of prescription drugs, subject to the Act and regulations. The Department proposes this amendment to clarify that reimbursement to employees is not subject to medical fee caps. Instead, medical providers' charges are subject to fee limitations.

The Department proposes amending § 127.134 (relating to payments for prescription drugs and pharmaceuticals – ancillary services of providers) to clarify the means of updating reimbursement rates for prescription drugs and pharmaceuticals.

The Department proposes reserving §§ 127.153 (relating to medical fee updates on and after January 1, 1995 – outpatient providers, services and supplies subject to the Medicare fee schedule); 127.154 (relating to medical fee updates on and after January 1, 1995 – inpatient acute care providers subject to DRGs plus add-on payment); 127.155 (relating to medical fee updates on and after January 1, 1995 – outpatient acute care providers, specialty hospitals and other cost-reimbursed providers); 127.156 (relating to medical fee updates on and after January 1, 1995 – skilled nursing facilities; 127.157 (relating to medical fee updates on and after January 1, 1995 – home health care providers); 127.158 (relating to medical fee updates on and after January 1, 1995 – outpatient and end-stage renal dialysis); 127.159 (relating to medical fee updates on and after January 1, 1995 – ASCs); 127.160 (relating to medical fee updates on and after January 1, 1995 – trauma centers and burn facilities); and 127.161 (relating to medical fee updates on and after January 1, 1995 – prescription drugs and pharmaceuticals) because their provisions have been incorporated into §§ 127.101-127.134.

The Department proposes amending § 127.201 (relating to medical bills generally) to require that providers request payment for medical bills and provide all required information to insurers within 90 days of the employee's first date of treatment with that provider. The Department further proposes amending the section to provide that failure to request payment as set forth in this section shall result in a waiver of any right to proceed against the insurer or claimant for payment of the bills. Additionally, the Department proposes adding a provision to clarify that providers may not bill or accept payment for services that are beyond the scope of their practice or licensure.

The Department proposes amending § 127.203 (relating to medical bills – submission of medical documentation) to provide grammatical corrections, and to further clarify that that medical information documenting billed treatment must be provided to the appropriate parties.

The Department proposes amending § 127.204 (relating to fragmenting or unbundling of charges by providers) to provide that fragmenting and unbundling of charges is only permitted where it is consistent with the most recent Medicare Correct Coding Initiative in effect on the date of service of the treatment, service or accommodation.

The Department proposes amending § 127.206 (relating to payment of medical bills – request for additional documentation) to clarify that requests for additional documentation do not alter insurers' obligations to timely make payment as provided in § 127.208 (relating to time for payment of medical bills).

The Department proposes amending § 127.207 (relating to downcoding by insurers) to make grammatical corrections, and to clarify that code changes must be consistent with the Correct Coding Initiative. The Department further proposes amending this section to require insurers to notify providers of the codes that result from the downcoding process. The Department proposes this amendment to clarify that proper downcoding practices require the insurer to arrive at a definitive conclusion regarding the code that it asserts is applicable. Insurers may not simply object to the code utilized by the provider without presenting an alternative code.

The Department proposes amending § 127.208 (relating to time for payment of medical bills) to provide grammatical corrections and to further require that providers submit medical documentation when submitting bills to insurers.

The Department proposes amending § 127.209 (relating to explanation of reimbursement) to amend references to "Explanations of Benefits (EOB)" to "Explanation of Reimbursement (EOR), which more accurately describes that document. Further, the Department proposes amending this section to require that EORs be in a format prescribed by the Department. The Department further proposes amending this section to require that providers use an EOR to detail reasons for denying or downcoding a medical bill. Finally, the Department proposes amending this section to require that the EOR contain specific information regarding the insurer's identity and the Bureau's fee review process.

The Department proposes adding § 127.209a (relating to adjusting and administering payment of medical bills) to require that any entity engaging in the business of adjusting and paying medical bills on the behalf of a provider, insurer, employee or self-insurer register with the Department under section 441(c) of the act (77 P.S. § 997(c)).

The Department proposes amending § 127.210 (relating to interest on untimely payments) to clarify that interest accrues on unpaid medical bills from the date upon which payment must originally be made under § 127.208 (relating to time for payment of medical bills).

The Department proposes amending § 127.211 (relating to balance billing prohibited) to further prohibit providers from billing patients for treatment related to reported work injuries unless the provider has submitted a written denial of liability. The Department further proposes amending this section to provide penalties for improper denials of liability, or failure to issue an EOR where one is required.

The Department proposes amending § 127.251 (relating to medical fee disputes – review by the Bureau) to reflect changes made in § 127.208 (relating to time for payment of medical bills).

The Department proposes amending § 127.252 (relating to application for fee review – filing and service) to eliminate the requirement that providers submit additional copies of fee review applications, and to clarify that fee reviews may be filed within 30 days of the first notification of a disputed treatment. The Department further proposes amending this section to provide grammatical corrections and to clarify the requirement that a proper proof of service must be filed with an application for fee review, and to provide for electronic filing.

The Department proposes amending § 127.253 (relating to application for fee review – documents required generally) to require that the application for fee review contain a copy of the first bill sent to the insurer, and to further provide for language consistent with §§ 127.203-127.208. Additionally, the Department proposes deleting requirements relating to material that pre-dated the Bureau's charge master.

The Department proposes amending § 127.255 (relating to premature applications for fee review) to provide the circumstances under which the Bureau will return applications for fee review.

The Department proposes amending § 127.256 (relating to administrative decision and order on an application for fee review) to provide that the Bureau may summarily deny applications for fee review where it is apparent that the application was not timely submitted. The Department further proposes amending this section to remove the requirement that the Bureau conduct an investigation, and to provide that the product of a fee review decision is an order of the Department, and may be amended or corrected to resolve typographical or mathematical errors.

The Department proposes amending § 127.257 (relating to contesting an administrative decision and order on a fee review) to remove requirements relating to additional copies, to clarify that filing and service must be made in a manner consistent with § 127.2 (relating to filing and service – computation of time), and to provide that requests for hearing must be signed.

The Department proposes amending § 127.258 (relating to Bureau as intervenor) to permit the Bureau to intervene in fee review hearings at any time.

The Department proposes amending § 127.259 (relating to fee review hearing) to clarify that a hearing officer may determine whether the request is timely and proper. The Department further proposes amending this section to clarify the procedural operations of the hearing process.

The Department proposes adding § 127.259a (relating to fee review hearing – burden of proof) to clarify the burdens of proof in fee review hearings.

The Department proposes amending § 127.260 (relating to fee review adjudications) to remove the requirement that the hearing officer issue decisions and orders within 90 days, and to clarify that such decisions and orders shall be mailed to counsel, if known.

The Department proposes amending § 127.302 (relating to resolution of referral disputes by Bureau) to provide that insurers asserting that the referral standards have been violated must do so through an EOB.

Subchapter D. Employer List of Designated Providers.

The Department proposes amending § 127.752 (relating to contents of list of designated providers) to require that lists of designated providers prominently include the names, addresses, telephone numbers, and area of medical specialties of listed providers. The Department further proposes amending this section to prohibit employers from requiring employees to schedule appointments through a single point of contact. Further, the Department proposes that reference to a single point of contact or referral for multiple providers on the list be considered a single provider, as is consistent with this section's provisions regarding Coordinated Care Organizations.

Subchapter E. Medical Treatment Review.

The Department proposes reserving the existing Subchapter C, and adding the following provisions in Subchapter E.

The Department proposes adding § 127.801 (relating to review of medical treatment generally) to provide that the Department will operate a Utilization Review (UR) process to permit review of reasonableness and necessity of treatment related to work injuries, that this review will be conducted by Utilization Review Organizations (UROs) authorized by the Secretary, that UR may be requested by or on behalf of employers, insurers or employees, and that providers, employees and insurers are parties to UR.

The Department proposes adding § 127.802 (relating to treatment subject to review) to provide that UR only applies to treatment rendered on and after August 31, 1993.

The Department proposes adding § 127.803 (relating to assignment of cases to UROs) to provide that the Bureau will assign requests for UR to authorized UROs, and that the Bureau will return requests for UR that are duplicative of existing UR requests or effective UR determinations.

The Department proposes adding § 127.804 (relating to prospective, concurrent and retrospective review) to provide that UR may be prospective, concurrent or retrospective, and may be requested by any party eligible under § 127.801 (relating to review of medical treatment generally).

The Department proposes adding § 127.805 (relating to requests for UR – filing and service) to provide procedural requirements relating to the filing and service of requests for UR.

The Department proposes adding § 127.805à (relating to UR of medical treatment prior to acceptance of claim) to provide a means for review of medical treatment prior to formal acceptance of a claim for benefits under the act.

The Department proposes adding § 127.806 (relating to requests for UR – assignment by the Bureau) to provide that the Bureau will assign the UR to an authorized URO and will notify the parties to the UR of this assignment.

The Department proposes adding § 127.807 (relating to requests for UR – reassignment) to provide for reassignment of UR requests where the URO is unable to perform a UR assigned to it by the Bureau.

The Department proposes adding § 127.808 (relating to requests for UR – conflicts of interest) to prohibit UROs from performing UR when a conflict of interest exists, and to identify situations that constitute a conflict of interest. The Department further proposes adding this section to provide that UROs may conduct recertification and re-determination reviews where they previously rendered a determination regarding the same treatment under review in the recertification or redetermination.

The Department proposes adding § 127.809 (relating to request for UR – withdrawal) to provide a procedure for withdrawal of a request for UR.

The Department proposes adding § 127.810 (relating to UR of entire course of treatment) to provide that insurers may request a review of all treatment rendered to an employee. The Department further proposes that this review may not affect the insurer's payment obligations regarding treatment rendered more that 30 days prior to the UR request. The Department further proposes that all treatment provided to an employee will be reviewed according to the providers' licenses and specialties, and that any inconsistencies between reviewers will be resolved through consultation of the involved reviewers.

The Department proposes adding § 127.811 (relating to pre-certification) to permit pre-certification of treatment proposed for a work-injury.

The Department proposes adding § 127.812 (relating to pre-certification – insurer obligations) to provide prerequisites for pre-certification, including requirements that the employee or provider first request preauthorization from the responsible insurer, and that the responsible insurer respond to the employee's or provider's request. The Department proposes this amendment to provide a streamlined mechanism for employees and providers to receive pre-approval of treatment options. The Department further proposes to permit providers and employees to rely upon USPS Form 3817 to demonstrate proof of mailing of the request.

The Department proposes adding § 127.813 (relating to pre-certification – provider-filed requests) to require that providers who file requests for pre-certification on behalf of employees detail the proposed treatment plan, procedure or referral, and serve a copy of the request on any providers to whom treatment may be referred.

The Department proposes adding § 127.814 (relating to pre-certification – employee-filed requests) to require UROs that receive employee-filed requests for pre-certification to contact the provider whose potential treatment is the subject of review and to request from that provider the treatment plan, procedure or referral relevant to the treatment under review within 10 days of the request. The Department further proposes that a provider's failure to supply information shall result in a determination that treatment is unreasonable and unnecessary, and that the URO must inform the provider of this determination.

The Department proposes adding § 127.815 (relating to assignment of proper requests for pre-certification) to permit the Bureau to assign requests for pre-certification to UROs in accordance with the provisions of this subchapter. Further, the Department proposes that the assignment of a UR request to a UR is interlocutory and is subject to review upon appeal of the UR determination.

The Department proposes adding § 127.816 (relating to prospective, concurrent and retrospective UR – insurer requests) to provide that insurers may request review of treatment that the employee is currently undergoing or may undergo in the immediate future.

The Department proposes adding § 127.817 (relating to concurrent and retrospective UR – payment obligations) to provide that insurers may suspend payment of bills issued within 30 days prior to the date of the UR request, but only insofar as the bills relate to the treatment under review. Further, the Department proposes tolling the 30-day period within which Insurers may request retrospective UR, and suspend payment of bills, pending an acceptance or determination of liability.

The Department proposes adding § 127.818 (relating to continuing effect of UR determinations) to provide for the continuing viability of UR determinations where treatment subject to review continues beyond the request. The Department proposes that determinations that treatment is reasonable and necessary continue to be effective to the extent specified in the determination. The Department further proposes establishing a process of recertification of reasonable and necessary treatment and further proposes that unreasonable/unnecessary treatment remains unreasonable and unnecessary until a change in the employee's condition merits redetermination of treatment. Finally the Department proposes establishing a process for redetermining the reasonableness and necessity of treatment.

The Department proposes adding § 127.819 (relating to requests for UR – recertification) to provide a process for recertifying that treatment that has been determined to be reasonable and necessary continues to be reasonable and necessary for some time into the future. The Department proposes establishing timelines for such recertification and providing that requests for recertification will be assigned to the URO that rendered the determination that treatment was reasonable and necessary.

The Department proposes adding § 127.820 (relating to requests for UR – redetermination) to provide a process for reviewing treatment that has been determined to be unreasonable or unnecessary, upon evidence that the employee's condition has changed such that the treatment may now be reasonable and necessary.

The Department proposes adding § 127.821 (relating to requesting and providing medical records) to require that UROs request records within 5 days of the date of the Notice of Assignment of a UR request. The Department further proposes a requirement that providers under review forward all records to the requesting URO within 15 days of the postmark date of the request, or within 7 days of the postmark date of a request for recertification or redetermination.

The Department proposes adding § 127.822 (relating to scope of review of UROs) to reflect that UROs may only address issues relevant to the reasonableness and necessity of the treatment under review. Further, the Department proposes that UROs may determine the extent to which treatment will remain reasonable and necessary into the future.

The Department proposes adding § 127.823 (relating to extent of review of medical records) to require UROs to attempt to obtain all available records of all treatment rendered for the work injury.

The Department proposes adding § 127.824 (relating to obtaining medical records – provider under review) to require UROs to request records from the provider under review in writ-

ing, and requiring the provider under review to sign a verification that the records are a true and complete copy of the employee's medical chart related to the work injury.

The Department proposes adding § 127.825 (relating to employee personal statement) to permit employees to submit a statement regarding the reasonableness and necessity of the treatment under review. The Department further proposes requiring the URO to inform the employee of the opportunity to submit a written statement, and providing timelines and guidance for consideration of the statement.

The Department proposes adding § 127.826 (relating to insurer submission of studies) to permit insurers to submit peer-reviewed, independently funded studies and articles to the URO, which may be relevant to the reasonableness and necessity of the treatment under review.

The Department proposes adding § 127.827 (relating to obtaining medical records – other treating providers) to require that UROs request records from all treating providers in writing, and eliminating the provision in the prior regulations that permitted records to be requested telephonically. The Department further proposes requiring providers to submit verifications attesting to the records.

The Department proposes adding § 127.828 (relating to obtaining medical records – independent medical exams) to prohibit UROs from requesting, and parties from supplying, independent medical examinations or material other than medical records and other material specifically referenced in this subchapter.

The Department proposes adding § 127.829 (relating to obtaining medical records – duration of treatment) to require UROs to attempt to obtain records relating to the entire course of treatment rendered to the employee for the work injury.

The Department proposes adding § 127.830 (relating to obtaining medical records – reimbursement of costs of provider) to require UROs to reimburse providers for copying costs incurred in responding to requests for records.

The Department proposes adding § 127.831 (relating to provider under review's failure to supply medical records) to require UROs to issue determinations that treatment is unreasonable and unnecessary where providers fail to respond to requests for records. Additionally, the Department proposes that providers may be prohibited from introducing evidence regarding treatment related to any UR request in which they failed provide medical records without reasonable cause or excuse. The Department further proposes to prohibit providers from billing for this treatment.

The Department proposes adding § 127.832 (relating to requests for UR – deadline for URO determination) to provide that requests for UR shall be deemed complete upon the earlier of receipt of the medical records or 18 days from the date of the notice of assignment. Additionally, the URO shall complete its review and render a determination within 20 days of a completed request for UR, or within 10 days of a completed request for recertification or redetermination.

The Department proposes adding § 127.833 (relating to assignment of UR request to reviewer) to provide that UROs will assign matters to reviewers having the same licenses and specialties as the providers under review.

The Department proposes adding § 127.834 (relating to duties of reviewers – generally) to require that reviewers apply the best available clinical evidence in rendering determinations regarding the reasonableness and necessity of treatment. Providers shall also specifically reference generally accepted treatment protocols, independently funded peer-reviewed studies, and reliable medical literature applicable in light of the diagnosis rendered by the provider under review. The Department further proposes that reviewers address only the reasonableness and necessity of the treatment under review, and that reviewers assume the existence of a causal relationship between the treatment and the work injury. Finally, the Department proposes adding a requirement that reviewers specifically note the timeframe within which treatment may continue to be reasonable and necessary. This timeframe may not exceed 180 days.

The Department proposes adding § 127.835 (relating to duties of reviewers – conflict of interest) to outline conflicts of interest applicable to reviewers' activities, and prohibits reviews where a conflict exists. The Department further proposes permitting reviewers to address treatment upon redetermination or recertification, even though they may have previously addressed treatment relating to the same matter.

The Department proposes adding § 127.836 (relating to duties of reviewers – content of reports) to define requirements for the contents of reviewers' reports.

The Department proposes adding § 127.837 (relating to duties of reviewers – signature and verification) to require that reviewers sign and verify reports that they author.

The Department proposes adding § 127.838 (relating to duties of reviewers – forwarding report and medical records to URO) to require that reviewers submit reports and records to the URO upon completion.

The Department proposes adding § 127.839 (relating to duties of UROs – review of report) to require UROs to ensure that the reviewer has complied with the act and regulations, and prohibit UROs from attempting to persuade reviewers to alter medical opinions expressed in reports.

The Department proposes adding § 127.840 (relating to form and service of determinations) to require that UROs sign UR determinations, and forward the determinations and other documentation to parties to UR disputes.

The Department proposes adding § 127.841 (relating to determination against insurer – payment of medical bills) to require insurers to make payment for treatment found to be reasonable and necessary. Additionally, the Department proposes amending this section to reflect that interest on medical bills continues to accrue throughout the UR process, and that payment obligations are merely tolled, and not extended, by the UR process. Finally, the Department pro-

poses amending this section to clarify that penalties may be appropriate where an insurer has failed to timely pay any medical bill or interest.

The Department proposes adding § 127.901 (relating to petition for review of UR determination) to provide that parties who disagree with a determination rendered by a URO may file a petition for review of a UR determination.

The Department proposes adding § 127.902 (relating to petition for review– time for filing) to require that petitions for review of UR determinations be filed within 30 days of the date of the determination.

The Department proposes adding § 127.903 (relating to petition for review – notice of assignment and service) to provide for assignment of petitions for review of UR determinations to workers' compensation judges, and service of the assignment on all parties to the UR determination.

The Department proposes adding § 127.904 (relating to petition for review – no answer allowed) to provide that no answer may be filed in response to a petition for review.

The Department proposes adding § 127.905 (relating to petition for review – transmission of records) to require UROs to forward all medical records obtained for its review to the workers' compensation judge assigned to rule on a petition for review of UR determination. The section further provides for forwarding the URO report, and requires that the URO verify the authenticity and completeness of the record. Finally, the section provides a means for the Bureau to reimburse the URO for copying costs associated with complying with this section.

The Department proposes adding § 127.906 (relating to petition for review by bureau – hearing and evidence) to provide that proceedings in response to petitions for review of UR determination are *de novo*. Workers' compensation judges are not bound by UR reports, and will consider the reports as evidence. Further, the Department proposes adding a provision clarifying that the workers' compensation judge may request peer review as a means to garner additional evidence regarding the reasonableness and necessity of the treatment under review, and that the workers' compensation judge may disregard evidence submitted by providers who failed to respond to the URO's request for records in the same matter.

The Department proposes adding § 127.1001 (relating to peer review – availability) to provide for peer review, during the litigation of a workers' compensation matter, of medical treatment related to the work injury.

The Department proposes adding § 127.1002 (relating to peer review – procedure upon motion of party) to provide the means and guidelines for parties and workers' compensation judges to request peer review.

The Department proposes adding § 127.1003 (relating to peer review – interlocutory ruling) to provide that the ruling on a motion for peer review is interlocutory.

The Department proposes adding § 127.1004 (relating to peer review – forwarding request to Bureau) to provide the process by which workers' compensation judges may request peer review.

The Department proposes adding § 127.1005 (relating to peer review – assignment by the Bureau) to provide the process by which the Bureau will assign requests for peer review to PROs.

The Department proposes adding § 127.1006 (relating to peer review – reassignment) to require PROs to return requests for peer review that they cannot perform.

The Department proposes adding § 127.1007 (relating to peer review – conflicts of interest) to define conflicts of interest and to require PROs to return requests for peer review where these conflicts occur.

The Department proposes adding § 127.1008 (relating to peer review – withdrawal) to provide a means for workers' compensation judges to withdraw requests for peer review.

The Department proposes adding § 127.1009 (relating to obtaining medical records) to provide mechanisms for PROs to retrieve medical records relating to a request for peer review.

The Department proposes adding § 127.1010 (relating to obtaining medical records – independent medical exams) to prohibit PROs from requesting, and the parties from supplying, documentation relating to litigation. Instead, this section as amended would require that only medical records of actual treating providers be provided to PROs.

The Department proposes adding § 127.1011 (relating to provider under review's failure to supply medical records) to require that PROs shall report a provider under review's noncompliance with a subpoena to the workers' compensation judge, and to prohibit the PRO from assigning matters to a review prior to receiving medical records.

The Department proposes adding § 127.1012 (relating to assignment of peer review request to reviewer by PRO) to require PROs to forward medical records and the Notice of Assignment to a reviewer licensed in the Commonwealth having the same license and specialty as the provider under review.

The Department proposes adding § 127.1013 (relating to duties of reviewers – generally) to require that the reviewers adhere to the requirements of § 127.834 (relating to duties of reviewers – generally).

The Department proposes adding § 127.1014 (relating to duties of reviewers – conflict of interest) to define conflicts of interest and to require a reviewer to return requests for peer review to the PRO where these conflicts occur.

The Department proposes adding § 127.1015 (relating to duties of reviewers – finality of decisions) to require reviewers to make definite determinations as to the necessity and frequency

of the treatment under review, to prohibit advisory opinions, and to require that reviewers resolve issues in favor of the provider under review where the reviewer is unable to determine the necessity or frequency of the treatment under review.

The Department proposes adding § 127.1016 (relating to duties of reviewers – content of reports) to provide the minimum requirements for reviewers' reports.

The Department proposes adding § 127.1017 (relating to duties of reviewers – signature and verification) to require that reviewers sign and verify their reports.

The Department proposes adding § 127.1018 (relating to duties of reviewers – forwarding report and records to PRO) to require reviewers to forward their report and the reviewed medical records to the URO.

The Department proposes adding § 127.1019 (relating to duties of PRO – review of report) to require that PROs check reviewers' reports to ensure compliance with formal requirements, to require that PROs ensure that the reviewer has returned all medical records, and to prohibit a PRO from contacting a reviewer and attempting to persuade the reviewer to change his opinion.

The Department proposes adding § 127.1020 (relating to peer review – deadline for PRO determination) to require a PRO to complete its review and render its determination within 15 days of its receipt of the medical records.

The Department proposes adding § 127.1021 (relating to PRO reports – filing with judge and service) to require that the PRO forward its report to the workers' compensation judge and provide listed parties with copies of the report via certified mail.

The Department proposes adding § 127.1022 (relating to PRO reports – evidence) to provide that the PRO report will be part of the record in the pending case, and that the workers' compensation judge must consider, but is not bound by, the report.

The Department proposes adding § 127.1023 (relating to PRO reports – payment) to require that PROs submit bills for services to the workers' compensation judge for approval.

The Department proposes adding § 127.1050 (relating to authorization of UROs/PROs) to provide that the Bureau may authorize UROs/PROs through contracts awarded under the Commonwealth Procurement Code, 62 Pa.C.S.A. § 101 *et seq.* The Department further proposes that the Bureau will not be required to award a contract to every offeror that submits a proposal that meets the minimum requirements established by the RFP.

The Department proposes adding § 127.1051 (relating to UROs/PROs authorized prior to (the effective date of these amendments)) to provide that UROs/PROs authorized prior to the effective date of these amendments remain authorized until the expiration of the authorization currently in effect.

Affected Persons

Those affected by these amendments include workers' compensation judges; Workers' Compensation Appeals Board commissioners and officials; and, employees of the Department. Those affected also include participants in the Pennsylvania workers' compensation system, including injured employees, health care providers, employers, workers' compensation insurers and their respective legal counsel.

Fiscal Impact

These amendments are expected to reduce costs to the Department and workers' compensation community by providing a more competitive environment for Utilization Review, and by easing the administrative burdens associated with the adjustment and payment of medical bills.

Reporting, Recordkeeping and Paperwork Requirements

These amendments require the creation of one new form, and require few modifications to existing forms. Therefore, the amendments do not impose any significant additional reporting, recording or paperwork requirements on either the Commonwealth or the regulated community.

Effective Date

These proposed amendments will be effective when published as final-form regulations in the *Pennsylvania Bulletin*.

Sunset Date

No sunset date is necessary for these amendments. The Department will continue to monitor the impact and effectiveness of the regulations.

Contact Person

Interested persons may submit written comments to the proposed rulemaking to Eileen Wunsch, Chief, Health Care Services Review Division, Bureau of Workers' Compensation, Department of Labor and Industry, Chapter 127 Regulations – Comments, P.O. Box 15121, Harrisburg, PA 17105, or to ra-li-bwc-administra@state.pa.us. Written comments must be received within 30 days of the publication of this proposed rulemaking in the *Pennsylvania Bulletin*. Written comments received by the Department may be made available to the public.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P.S. § 745.5(a)), on May 26, 2006, the Department submitted a copy of this proposed rulemaking and a copy of a Regulatory Analysis Form to the Independent Regulatory Review Commission (IRRC)

and to the Chairpersons of the Senate Committee on Labor and Industry and the House Labor Relations Committee. A copy of this material is available to the public upon request.

Under section 5(g) of the Regulatory Review Act, IRRC may convey any comments, recommendations or objections to the proposed rulemaking within 30 days of the close of the public comment period. The comments, recommendations or objections must specify the regulatory review criteria which have not been met. The Regulatory Review Act specifies detailed procedures for review, prior to final publication of the rulemaking, by the Department, the General Assembly and the Governor of comments, recommendations or objections raised.

Stephen M. Schmerin
Secretary

FISCAL NOTE: 12-72

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. Filing and service -- 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.]

(a) A filing required by this chapter is deemed complete upon delivery in person or, if by mail, upon deposit in the United States Mail, as evidenced by a United States Postal Service postmark, properly addressed, with postage or charges prepaid.

(b) Service required by this chapter is deemed complete upon delivery in person or, if by mail, upon deposit in the United States Mail, as evidenced by a United States Postal Service postmark, properly addressed, with postage or charges prepaid.

(c) Proof of service required by this chapter shall contain all of the following:

(1) A statement of the date of service.

(2) The names of the individuals and entities served.

(3) The mailing address, the applicable zip code and the manner of service on the individuals and entities served.

(d) Unless otherwise specifically provided in this chapter, filing or service required to be made upon the Bureau shall be made to the Health Care Services Review Division of the Bureau at: 1171 South Cameron Street, Harrisburg,

Pennsylvania 17104-2501, (717) 783-5421 or another address and telephone number as may be published in the *Pennsylvania Bulletin* or as set forth on the applicable Bureau form.

(e) Subsections (a)—(d) supersede 1 Pa. Code §§ 31.5, 31.11, 31.12, 31.13, 31.14, 31.15, 31.26, 33.32 and 33.34—33.37.

§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] that is referred to by [HCFA] CMS as an [ASCs] ASC and is licensed by the Department of Health as an [ASFs] ASF. [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 specialty board — A specialty 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 and 2501-2506).

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 a rehabilitation [and] or psychiatric provider.

Approved teaching program — A hospital teaching program [which] that 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, or a successive mechanism used by Medicare to determine program reimbursement costs or rates.

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

Bureau Code – The numeric identifier that the Bureau may assign to each insurer, self-insurer or third-party administrator authorized to provide services in this Commonwealth.

Burn facility — A facility [which] that 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] to provide medical services to injured employes.

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

CMS – The Centers for Medicare & Medicaid Services, formerly referred to as the Health Care Financing Administration (HCFA).

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 listing of cost-based reimbursable providers' [provider's listing of current charges] rates of reimbursement for procedures and supplies utilized in the [provider's] provider's billing [process] processes.

Commissioner — The Insurance Commissioner of the Commonwealth.

Concurrent review – Utilization Review of treatment rendered to an employee conducted during the course of the treatment.

Correct coding initiative – The National Correct Coding Initiative developed and published by or on behalf of CMS to promote national coding methodologies.

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.] Equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose and that provides therapeutic benefit, or enables injured employees to perform certain tasks that they are unable to undertake otherwise due to their medical conditions or illnesses.

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.

Downcode – Altering or amending the HCPCS, CPT, DRG, ICD or other code that a provider utilized to seek payment for a particular treatment, service or accommodation.

EOR - Explanation of reimbursement – A document, in a format prescribed by the Department, that explains an insurer's decision to pay, downcode or deny payment of a medical bill or bills.

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 or the Centers for Medicare & Medicaid Services (CMS).

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] — The International Classification of Diseases, identified by its edition and modification (i.e., ICD-9-CM = 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] Workers' 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,] Correspondence from the HCFA, CMS, Medicare or a Medicare intermediary to a [the] provider[,] that informs [informing] the provider of [their] its 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.

Medical records -- Written information that accurately, legibly and completely reflects the evaluation and treatment of the patient. Correspondence with individuals or entities not involved in evaluating and treating the patient, such as legal counsel, payer representatives, or case-management personnel not actually providing patient care, are not medical records under this chapter.

Medical Reports – Documentation that providers are required to submit to insurers under section 306 (f.1)(6) of the act (77 P.S. § 531(2)) and § 127.203 (relating to medical bills, submission of medical documentation), that includes information regarding an injured employee's medical history, diagnosis, treatment and services rendered, and medical records documenting billed treatment.

Medical Report Form – The form designated by the Department under section 306(f.1)(6) of the act and § 127.203 (relating to medical bills-submission of medical documentation).

Medicare carrier — An organization with a contractual relationship with [HCFA] CMS to process Medicare Part B claims.

Medicare intermediary — An organization with a contractual relationship with [HCFA] CMS 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] that began administering patient care after receiving initial licensure on or after August 31, 1993.

Notice of [biweekly] payment rates — [The letter of notification] A notice from the Medicare intermediary to the provider, informing the provider of [their] its [biweekly] payment rate for direct medical education and paramedical education costs.

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

Notification of disputed treatment – An EOR, a written denial of payment, or a Utilization Review Determination Face Sheet.

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.

Pre-certification – Prospective review, sought by an employee or provider, to determine whether future treatment is reasonable and necessary.

Provider — A health care provider.

Provider under review -- A provider that, within the context of a particular UR or Peer Review request, provides or orders the health care services for which utilization or peer review is requested. Where treatment is provided or ordered by

a provider whose activities are subject to direction or supervision by another provider, the directing or supervising provider shall be the provider under review.

Prospective review – UR of proposed treatment that is conducted before the treatment is provided.

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

Recertification – UR of prospective treatment previously determined to be reasonable and necessary, that may certify that the treatment will continue to be reasonable and necessary for a fixed period of time.

Re-determination – UR of prospective treatment previously determined to be unreasonable and unnecessary.

Retrospective review – UR of treatment that was already provided to an employee.

Secretary — The Secretary of the Department.

Service code – The code assigned to each provider's individual treatment, service or accommodation as contained in the charge master maintained by the Bureau.

Service descriptor – The written description of each provider's individual treatment, service or accommodation as contained in the charge master maintained by the Bureau.

Specialty -- Certification by a specialty board recognized by the American Board of Medical Specialties or the American Osteopathic Associations' Bureau of Osteopathic Specialists.

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.

Statewide average weekly wage – The amount determined annually by the Department, under section 105.1 of the Act (77 P.S. § 25.1) for each calendar year on the basis of employment covered by the Pennsylvania Unemployment Compensation Law (43 P.S. §§ 751- 914) for the 12-month period ending June 30 preceding the calendar year.

[*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).

Treatment -- The management and care of a patient for the purpose of combating disease or disorder.

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, as evidenced by a database published or referenced by the Department in the *Pennsylvania Bulletin*.

Workers' [C]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 – general provisions and initial rates for treatment rendered before January 1, 1995[— 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)] this chapter.

(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] 127.135.

(e) Medical fee caps based on Medicare will apply to all providers licensed in this Commonwealth who treat injured workers, regardless of whether the 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 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, required by the act and this chapter, 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 CPT or 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).]

Payment for services rendered under this section on and after January 1, 1995, shall be frozen as of December 31, 1994 and updated annually by the percentage change in the Statewide average weekly wage.

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

(g) On and after January 1, 1995, payment rates under the act for new CPT or HCPCS codes will be based on the rates allowed in the Medicare fee schedule published in the *Federal Register* within the calendar years of 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.

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

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

(b) Payment for services rendered under this section on and after January 1, 1995, shall be frozen as of December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.

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

(d) On and after January 1, 1995, payment rates under the act for new CPT or HCPCS codes will be based on the rates allowed in the Medicare fee schedule published in the *Federal Register* within the calendar year of 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.

§ 127.105. 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 initially be based on the Medicare fee schedule for the appropriate CPT or HCPCS codes [98940 - 98943], multiplied by 113%.

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

(d) Payments shall be made for documented office visits and shall initially be based on the appropriate [Medicare fee schedule for] CPT or 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] appropriate level CPT or 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[]].

(f) Payment for services rendered under this section on and after January 1, 1995, shall be frozen as of December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.

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

(h) On and after January 1, 1995, payment rates under the act for new CPT or HCPCS codes will be based on the rates allowed in the Medicare fee schedule published in the *Federal Register* within the calendar years of 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.

§ 127.106. 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 initially be based on the [Medicare fee schedule for] appropriate level CPT or 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] appropriate level CPT or 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[])].

(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).

(d) Payment for services rendered under this section on and after January 1, 1995 shall be frozen as of December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.

(e) On and after January 1, 1995, adjustments and modifications by CMS relating to a change in description or renumbering of a CPT or HCPCS code will be

incorporated into the basis for determining the amount of payment as frozen under subsection (d) for services rendered under the act.

(f) On and after January 1, 1995, payment rates under the act for new CPT or HCPCS codes will be based on the rates allowed in the Medicare fee schedule published in the *Federal Register* within the calendar years of 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.

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

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

(b) Payment for services rendered under this section on and after January 1, 1995 shall be frozen as of December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.

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

(d) On and after January 1, 1995, payment rates under the act for new CPT or HCPCS codes will be based on the rates allowed in the Medicare fee schedule published in the *Federal Register* within the calendar years of 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.

§ 127.108. Durable medical equipment and home infusion therapy.

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

(b) Payment for services rendered under this section on and after January 1, 1995 shall be frozen as of December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.

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

(d) On and after January 1, 1995, payment rates under the act for new CPT or HCPCS codes will be based on the rates allowed in the Medicare fee schedule published in the *Federal Register* within the calendar years of 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.

§ 127.109. 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. The supplies shall be specifically identified on the HCFA 1500 or UB 92 form applicable to the treatment rendered. 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, as updated under § 127.111a (relating to inpatient acute care providers – DRG updates):

(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%, except as set forth in § 127.111a (relating to inpatient acute care providers – DRG updates).

(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.

§ 127.111a. Inpatient acute care providers – DRG updates.

(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 using the DRG Grouper, relative weight, Geometric and Arithmetic Mean Lengths of Stay and Outlier thresholds in effect on the date of discharge.

(b) 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.

(c) 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 interim rate notification in effect on December 31, 1994. These frozen rates shall be applied to the DRG rates in effect on the date of discharge, as set forth 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 DRG rates in effect on the date of discharge, as set forth in subsection (a).

(d) On and after January 1, 1995, add-on payments based on cost-to-charge outliers as set forth in § 127.114 (relating to inpatient acute care providers — outliers) shall be frozen based on the thresholds and calculations in effect on December 31, 1994. These payments may not be updated based on changes in the Statewide average weekly wage.

(e) 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 DRG rates in effect on the date of discharge, as set forth in subsection (a).

(f) 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 DRG rates in effect on the date of discharge, as set forth in subsection (a).

(g) 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.

§ 127.112. 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:] by multiplying 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] interim rate notification 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:] by adding 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] payment rates. 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] payment rates. 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 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] Costs in excess of [the threshold] $36,000 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] CMS 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] CMS 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] Disproportionate-share hospitals shall be reimbursed by multiplying [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, the product of which shall [and] then be 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] may not 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 reimbursed [calculated as follows:] by multiplying the hospital's payment rate identified on the latest [Medicare] interim rate [notice shall be multiplied] notification by the DRG payment on the date of discharge, [and] the product of which shall then be 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] may not [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].

(a) The following services shall be paid on a cost-reimbursed basis for medical treatment rendered under [Act 44] the act:

(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.

(b) As of December 31, 1994, the provider's actual charge by procedure as determined from the charge master shall be multiplied by the ratio of cost-to-charges, based on the most recently audited Medicare cost report. Except as stated in subsection (c), this amount shall be frozen as of December 31, 1994 for purposes of calculating payments under the act and updated annually by the percentage change in the Statewide average weekly wage.

(c) To calculate rates frozen in subsection (b) the Bureau will multiply the provider's billed charges by the RCC associated with the appropriate Revenue Code. The appropriate Revenue Code is the Revenue Code that applies to the corresponding service descriptor in the charge master as of September 1, 1994, or the Revenue Code that applies to the corresponding service descriptor added to the chargemaster under subsection (f)(2).

(d) Subsection (b) will not apply where the charge master does not contain unique charges for each item of pharmacy and where 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 reimbursement. These payments may not be updated based on changes in the Statewide average weekly wage.

(e) Providers that are reimbursed under this section and add new services requiring the addition of new service descriptors within previously reported Medicare revenue codes and frozen RCCs shall receive payment based on the charge associated with the new service multiplied by the frozen RCC.

(f) Providers that are reimbursed under this section and add new services requiring the addition of new service descriptors outside of the previously reported Medicare revenue codes and frozen RCCs, shall receive payment as follows:

(1) Before the completion of the audited cost report that 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 that includes the new services, payment shall be based on the charge associated with the new service multiplied by the audited RCC including the charge. Payment rates shall be frozen immediately and updated annually by the percentage change in the Statewide average weekly wage.

(g) Providers reimbursed under this section that, commencing (the effective date of this regulation), add new services for which such providers are reimbursed by Medicare on a fee-for-service basis, shall receive reimbursement according to the procedures established under this chapter for Medicare Part B services.

(h) Providers that are reimbursed under this section and add new services under subsections (f) or (g) shall provide the service descriptor, HCPCS codes, applicable Medicare revenue codes and applicable cost data to the Bureau within 30 days of the date on which the provider first provides the new service. The Bureau will include all reimbursement rates relating to the new service in the next publication of the charge master. Providers shall thereafter be reimbursed for such service as set forth in the charge master, and may not assert that the service is new as set forth in subsection (f)(1).

§ 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(a)(1) (relating to outpatient acute care providers, specialty hospitals and other cost reimbursed providers [not subject to the Medicare fee schedule]) shall initially be calculated [as follows:] by multiplying the provider charge [shall be multiplied] by the applicable RCC, the product of which [then] shall then be multiplied by 113%. This amount shall be updated as set forth in § 127.117.

(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(a)(2) shall initially be calculated as follows, and updated as set forth in § 127.117:

(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] CMS 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] provided in [subsection (c)] this section, payments for services listed in § 127.117(a)(3), (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 by multiplying [as follows:] the provider's charge [shall be multiplied] by the applicable RCC, the product of which [then] shall then be multiplied by 113%. This amount shall be updated as set forth in subsection (d).

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

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

(1) For providers whose basis of Medicare apportionment is gross charges, the RCC shall be developed by dividing the total departmental cost for each therapy department on line 4 of Schedule C 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 department 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%.

(d) On and after January 1, 1995, payments to CORFs and outpatient physical therapy centers under this section, shall be frozen and updated as follows:

(1) For providers whose basis of Medicare apportionment is gross charges, payment rates shall be frozen as of 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 therapy 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.

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

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

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

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

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

(b) If the cost-reimbursed provider loses its right to receive add-on payments for medical education costs under the Medicare Program, it [shall also lost its right to] may not 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] may 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 rates [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.

(d) On and after January 1, 1995, add-on payments based on medical education costs under this section 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, may not receive these payments under the act. 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, may receive payments based on the rates calculated in this section. These rates shall be frozen immediately and shall be updated annually by the percentage change in the Statewide average weekly wage.

§ 127.122. Skilled nursing facilities.

(a) 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:] by multiplying the most recent Medicare interim per diem rate [shall be multiplied] by the number of patient days, the product of which shall [and] then be multiplied by 113%.

(b) On and after January 1, 1995, the payment set forth in subsection (a) shall be frozen as of December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.

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

(a) 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:] by multiplying 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.

(b) On and after January 1, 1995, the payment set forth in subsection (a) shall be frozen as of December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.

§ 127.124. Outpatient and end-stage renal dialysis payment.

(a) Payments to providers of outpatient and end-stage renal dialysis shall be calculated by multiplying [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).

(c) On and after January 1, 1995, payments to providers of outpatient and end-stage renal dialysis under subsection (a) shall be frozen on December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.

§ 127.125. ASCs.

(a) Payments to providers of outpatient surgery in an ASC [,] licensed by the Department of Health shall be based on the ASC payment groups defined by CMS [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, payment shall be based on 80% of the usual and customary charge.]

(b) On and after January 1, 1995, payments to providers of outpatient surgery in ASCs under subsection (a) shall be frozen as of December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.

§ 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, specialty 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 § 127.119 (relating to payments for services using RCCs) [§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 of each 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.

(i) Trauma centers and burn facilities shall continue to receive their usual and customary charges on and after January 1, 1995, as set forth in this section.

§ 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.

(b) Office notes and other documentation which are necessary to support provider codes billed [may not be considered] are not special reports. Providers may not request payment for these notes and documentation. [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] is not 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. The AWP shall be established by the most recent edition of the "Drug Topics Redbook," published by Medical Economics Company of Montvale, NJ or its successor.

(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.]

Pharmacists may not bill or 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.

(c) Pharmacists dispensing prescriptions for injuries compensable under the act shall comply with the act of November 24, 1976 (P.L. 1163, No. 259) (35 P.S. §§ 960.1 – 960.7) known as the Generic Equivalent Drugs Act.

§ 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, except as provided in Subchapter D of these regulations (relating to employer list of designated providers).

§ 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] The insurer shall reimburse the injured employe for the actual [cost] costs of [the] prescription drugs [, once liability has been admitted or determined] as provided in the act and this chapter.

§ 127.134. Payments for prescription drugs and pharmaceuticals — ancillary services of providers.

(a) 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%.

(b) On and after January 1, 1995, payments for prescription drugs and professional pharmaceutical services shall be limited to 110% of the average wholesale price.

§ 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 (AWP) of the product.

(b) Physicians may not bill or 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] the act, except as permitted in this chapter.

(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.]

(Reserved)

§ 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.]

(Reserved)

§ 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 costs as set forth in § 127.121 (relating to cost-reimbursed providers—medical education costs) shall be frozen based on the calculations made using the Medicare Cost Report. These rates shall be updated annually by the percentage change in the Statewide average weekly wage.

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

(2) Cost-reimbursed providers that gain the right to receive add-on payments based on medical education costs under the Medicare Program on and after

January 1, 1995, shall receive payments based on the rates calculated in § 127.121. These rates shall be frozen immediately and shall be updated annually by the percentage change in the Statewide average weekly wage.

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

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

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

(Reserved)

§ 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.]

(Reserved)

§ 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.]

(Reserved).

§ 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.]

(Reserved)

§ 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.]

(Reserved)

§ 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).]

(Reserved)

§ 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.]

(Reserved)

§ 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] generally.

(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] descriptors consistent with the service [descriptors] codes submitted to the Bureau in accordance with § [127.155(b)] 127.117 (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] descriptors added under §[127.155(d) and (e)] 127.117(d)-(i).

(c) Providers shall request payment for medical bills and provide all applicable reports required under § 127.203 (relating to medical bills – submission of medical documentation) within 90 days from the first date of treatment reflected on the bill.

(d) No provider may seek payment from the insurer or employee if the provider failed to request payment within the time set forth in subsection (c).

(e) No provider may bill, accept payment for, or attempt to recover from the employee, employer or insurer, charges relating to services that are beyond the scope of the provider's practice or licensure, under the laws of the jurisdiction where the services are performed.

§ 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] generally) 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] documentation.

(a) Providers who treat injured employes [are required to submit periodic] shall periodically submit [medical reports] 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 has insured its workers' compensation liability [is covered by an insurer], the provider shall instead submit the [report] Medical Reports to the insurer. If the employer is self-insured, the provider shall submit the Medical Reports to the employer, or to the employer's agent or administrator if the employer has informed the provider that the agent or administrator is the proper billing recipient for the patient.

(b) Providers are not required to submit Medical Reports [Medical reports are not required to be submitted in] for months during which no 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.] Providers shall submit the Medical Reports required by subsection (a) with the Medical Report Form.

(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.] In submitting the Medical Report Form and Medical Reports, the provider shall provide all of the following:

(1) Information on the employee's history.

(2) The employee's diagnosis.

(3) A description of the treatment and services rendered to the employee.

(4) The physical findings and prognosis, including whether there has been recovery enabling the employee to return to pre-injury work without limitations.

(5) All medical records documenting the billed treatment.

(e) The insurer is not obligated to make payment until 30 days after its receipt of the bill, Medical Reports, and the Medical Report Form.

§ 127.204. Fragmenting or unbundling of charges by providers.

A provider may not fragment or unbundle charges except as consistent with the Correct Coding Initiative in effect on the date of service.

§ 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] An insurer may make changes to a provider's codes [be made] if all of the following conditions are met:

(1) The provider has been notified in writing of the proposed code changes and the reasons in support of the changes.

(2) The provider has been given an opportunity to discuss the proposed code changes and support the original coding decisions.

(3) The insurer has sufficient information to make the code changes.

(4) The code changes are consistent with [Medicare guidelines] the Correct Coding Initiative, 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 code 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 inform the provider of the code that it asserts is correct and shall state the reasons why the provider's original codes were changed in the [EOB] EOR required by § 127.209 (relating to explanation of [benefits] reimbursement 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.

§ 127.208. Time for payment of medical bills.

(a) Payments for treatment rendered under the act shall be made within 30 days of the insurer's receipt of the bill, Medical Reports, and Medical Report [report] Form required by § 127.203 (relating to medical bills – submission of medical documentation) [submitted by the provider].

(b) For purposes of computing the timeliness of payments, the insurer shall be deemed to have received [a] the bill, [medical records] Medical Reports and [report] Medical Report Form 3 days after mailing by the provider. Payments shall be deemed timely made if mailed on or before the 30th day following receipt of all of [the bill and report] these documents.

(c) If an insurer requests additional information or records from a provider under § 127.206 (relating to payment of medical bills — request for additional documentation), 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 code 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] E (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 reimbursement paid.

(a) Insurers shall supply a written [explanation of benefits (EOB)] EOR to the provider, in a Department - prescribed format [describing] explaining the insurer's decision to pay, downcode, or deny [calculation of] payment of medical bills submitted by the provider. Insurers shall supply the EOR within 30 days of the insurer's receipt of the documentation required by § 127.203 (relating to medical bills – submission of medical documentation).

(b) If payment is based on changes to a provider's codes, the [EOB] EOR shall state the reasons for changing the original codes and shall state the codes that the insurer asserts are correct. If payment of a bill or service is denied entirely, an insurer [insurers] shall [provide a written explanation for the denial] in the EOR, inform the provider whether:

(1) The insurer disclaims liability for the employee's injury.

(2) The insurer asserts that the treatment provided is not related to the employee's work-injury.

(3) The insurer has not received the documentation required by § 127.203 (relating to medical bills – submission of medical documentation).

(4) The insurer asserts that the provider failed to bill within the time permitted by § 127.201 (relating to medical bills -- generally).

(5) The insurer requested utilization review of the billed treatment.

(6) The insurer asserts that the billed treatment was rendered in violation of the referral standards of § 127.301 (relating to referral standards).

(c) All [EOBs] EORs shall prominently display the Bureau Code and name of the insurer and 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.["] If you believe that payment has been incorrectly calculated or is untimely, you may file an application for fee review with the Bureau of Workers' Compensation."

§ 127.209a. Adjusting and administering the payment of medical bills.

A person or entity that engages in calculating reimbursement or paying medical bills under §§ 127.201- 127.209, on behalf of a provider, insurer, employer or self-insurer, is engaged in the business of adjusting or servicing injury cases under section 441(c) of the act (77 P. S. § 997(c)).

§ 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] as required by § 127.208 (relating to time for payment of medical bills), 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 from the date by which payment must be made under § 127.208, even if an insurer initially denies liability for the bills, [if] where liability is later admitted or determined.

(d) Interest shall accrue on unpaid medical bills from the date by which payment must be made under § 127.208, even if an insurer has filed a request for UR under

Subchapter [C] E (relating to medical treatment review), where [if a] it is later [determination] determined [is made] that the insurer was liable for paying the bills.

§ 127.211. Balance billing prohibited.

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

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

(c) A provider may not bill, accept payment for, or attempt to recover from the employee, charges relating to treatment rendered for a reported work injury until the provider has received an EOR from the insurer denying that the treatment is related to the work injury or denying liability for a work injury.

(d) An insurer that issues an EOR containing an improper or incorrect denial of liability, or that fails to issue an EOR required by the act or this chapter, violates the act and this chapter under section 435 of the act (77 P.S. § 991).

REVIEW OF MEDICAL FEE DISPUTES

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

A provider who has submitted the required bills, [and reports] Medical Reports, and Medical Report Forms to [an] the appropriate insurer and who disputes the amount or timeliness of the payment made by [an] the 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 for fee review 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[,] or 30 days following the insurer's receipt of the first notification of a disputed treatment, whichever is later. Under this section, the insurer shall be deemed to have received a notification of disputed treatment three days after the notification is deposited in the United States Mail. 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 of [for] the application for fee review[,] and the attached documents[,] required by § 127.253 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) The application shall include a proof of service which shall be completed and signed by the provider as required by § 127.2 (relating to filing and service – computation of time) and shall indicate the person served, the date of service and the form of service.

(d) The Bureau will return any application which is incomplete or on which the proof of service has not been signed.

(e) Providers shall send the application for fee review and all related attachments to the address for the Bureau listed on the application form, or file the application for fee review electronically as the Bureau may permit.

(f) The time for filing an application for fee review will be tolled while [if] the insurer has the right to suspend payment to the provider under § 127.208 (relating to time for payment of medical bills) due to a dispute regarding the reasonableness and necessity of the treatment under Subchapter [C] E (relating to medical treatment review).

(g) Subsections (a)—(f) supersede 1 Pa. Code §§ 31.5, 31.11, 31.12, 31.13, 31.14, 31.15, 31.26, 33.31, 33.32 and 33.34—33.37.

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

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

(1) [The applicable Medicare billing form.] A copy of the first bill submitted to the insurer under § 127.201 (relating to medical bills – generally).

(2) [The] A copy of the required [medical report] Medical Report [form] Form, together with [office notes] the Medical Reports and documentation supporting the procedures performed or services rendered required under § 127.203 (relating to medical bills – submission of medical documentation).

(3) [The] A copy of the [explanation of benefits] EOR, 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 reimbursement, 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.]

This section supersedes 1 Pa. Code §§ 31.5, 31.11, 31.12, 31.13, 31.14, 31.15, 31.26, 33.31, 33.32 and 33.34—33.37.

§ 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.

(a) The Bureau will return, and will not issue administrative decisions and orders on applications for fee review [prematurely] filed by providers [when one of the following exists] for any of the following reasons:

(1) The insurer [denies] has issued an EOR denying liability for the alleged work injury or denying that the treatment is causally related to the work injury.

(2) The insurer accurately informs the Bureau that it has filed a request for utilization review of the treatment under Subchapter [C] E (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).

(b) This section supersedes 1 Pa. Code §§ 31.5, 31.11, 31.12, 31.13, 31.14, 31.15, 31.26, 33.31, 33.32 and 33.34—33.37.

§ 127.256. Administrative decision and order on an application for fee review.

(a) [When] The Bureau will render an administrative decision and order if a provider has filed [all] the application, proof of service and all documentation required by § 127.203 (relating to medical bills – submission of medical documentation) unless the application will be returned under § 127.255 (relating to premature applications for fee review). [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].

(b) [The Bureau will, prior]Before [to] rendering [the administrative] its decision and order, [investigate the matter and] the Bureau may contact the insurer to obtain its response to the application for fee review. If the Bureau can determine from the application and documentation submitted by the provider that the application was not submitted within the time permitted by § 127.252 (relating to

application for fee review – filing and service), it will not contact the insurer and will issue an administrative decision and order denying the application.

(c) The Bureau may correct or amend typographical or mathematical errors in its administrative decision and order within 15 days of rendering its administrative decision and order.

(d) Subsections (a)—(c) supersede 1 Pa. Code §§ 31.5, 31.11, 31.12, 31.13, 31.14, 31.15, 31.26, 33.31, 33.32 and 33.34—33.37.

§ 127.257. Contesting an administrative decision and order on a fee review.

(a) A provider or insurer shall have the right to contest an adverse administrative decision and order on an application for fee review.

(b) The party contesting the administrative decision and order shall, file [an original and seven copies of] a written request for a hearing with the Bureau on a Bureau-prescribed form within the later of 30 days of the date of the administrative decision and order on the fee review, or 30 days of the date of any corrected or amended administrative decision and order issued under § 127.256(c) (relating to an administrative decision and order on an application for fee review). The hearing request shall be [mailed to the Bureau at the address listed on the administrative decision] filed with the Bureau, signed by the appellant or its counsel, and served on all parties as required by § 127.2 (relating to filing and service – computation of time). A signature stamp may not be used.

(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.] Filing of a request for a hearing shall act as a supersedeas of the administrative decision and order on the fee review.

(d) Subsections (a)—(c) supersede 1 Pa. Code §§ 31.5, 31.11, 31.12, 31.13, 31.14, 31.15, 31.26, 33.31, 33.32, 33.34—33.37, 35.1-35.16 and 35.18-35.41.

§ 127.258. Bureau as intervenor.

(a) The Bureau may [, as an intervenor] intervene as a party in the fee review matter [, defend the Bureau's initial administrative decision on the fee review].

(b) This section supersedes 1 Pa. Code §§ 35.27-35.32.

§ 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.] If a request for hearing was timely and properly filed, the hearing officer will schedule one or more hearings. The hearing officer will notify all parties of hearing dates, times and places. If a request for hearing does not appear to have been timely or properly filed, the hearing officer may dismiss the request without further action, or may schedule a hearing to determine whether the request was timely and properly filed.

(b) The hearing officer may require that the parties complete a pre-hearing filing regarding the underlying fee dispute.

(c) All hearings [The hearing] will be conducted in a manner to provide all parties the opportunity to be heard, and will be governed by applicable provisions of 1 Pa. Code Part II (relating to general rules of administrative practice and procedure) unless this chapter supersedes these rules. 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.

(d) [The parties may be represented by legal counsel, but legal representation at the hearing is not required.] Legal representation at the hearing is governed by 1 Pa. Code Chapter 31, Subchapter C (relating to representation before agency).

(e) Testimony will be recorded and a full record kept of the proceeding.

(f) All parties will be provided the opportunity to submit briefs addressing issues raised. [The insurer shall have the burden of proving by a preponderance of the evidence that it properly reimbursed the provider.]

(g) Subsections (a)—(f) supersede 1 Pa. Code §§ 31.5, 31.11, 31.12, 31.13, 31.14, 31.15, 31.26, 33.31, 33.32, 33.34—33.37, 35.1-35.24, 35.35, 35.37-35.41 and 35.54.

§ 127.259a. Fee review hearing -- burden of proof.

(a) Where proper reimbursement is disputed, the insurer shall have the burden of proving by a preponderance of the evidence that it properly reimbursed the provider.

(b) Where a party alleges that procedural requirements have not been met or that the provider did not timely file its application for fee review, the party making the allegation shall have the burden of proving by a preponderance of the evidence that the opposing party has failed to meet these requirements.

(c) The hearing officer will dismiss an application for fee review where the application is premature under § 127.255 (relating to premature applications for fee review).

(d) The hearing officer may dismiss a request for hearing where the moving party fails to appear and present evidence at a scheduled hearing.

(e) Subsections (a)—(d) supersede 1 Pa. Code §§ 31.5, 31.11, 31.12, 31.13, 31.14, 31.15, 31.26, 33.31, 33.32, 33.34—33.37, 35.1-35.24, 35.35, 35.37-35.41, 35.54, 35.201-35.202, and 35.205 – 35.214.

§ 127.260. Fee review adjudications.

(a) The hearing officer will issue a fee review adjudication consisting of a written decision and order [within 90 days] following the close of the record. The decision and order 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] their attorneys, if known.

(d) Subsections (a)—(c) supersede 1 Pa. Code § § 1 Pa. Code §§ 31.5, 31.11, 31.12, 31.13, 31.14, 31.15, 31.26, 33.31, 33.32, 33.34—33.37, 35.1-35.24, 35.35, 35.37-35.41, 35.54, 35.201-35.202, and 35.205 – 35.214, and 35 Pa. Code Ch. 35, Subchapter H.

§ 127.261. Further appeal rights.

A 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 of the [from] mailing date 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 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 referral disputes by Bureau.

(a) If an insurer determines that a [bill has been submitted for] billed treatment has been rendered in violation of the referral standards, the insurer is not [liable] required to pay the bill. [Within 30 days of receipt of the provider's bill and medical report, the] An insurer shall supply a written [explanation of benefits] EOR under § 127.209 (relating to explanation of reimbursement paid), stating the

basis for believing that the [self-referral provision has] referral standards have 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] referral standards has occurred.

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] may 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] that 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 seek medical treatment from any provider 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 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 prominently include the names, addresses, telephone numbers and area of medical specialties of each of the designated providers on the list. The employer may not require the employe to report to a single point of contact before receiving treatment from a provider on the list.

(c) The employer shall include on the list only providers who are geographically accessible and whose specialties are appropriate base 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) If the list references a single point of contact or referral for more than one provider on the list, all providers associated with the point of contact or referral shall be considered a single provider under subsection (a).

(f) 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] E (relating to medical treatment review).

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

(c) The written notice to an employee of the employee's rights and duties under this section shall be provided at the time the employee is hired and immediately after the injury, or as soon thereafter as possible under the circumstances of the injury. If the employee's injuries are so severe that emergency care is required, notice of the employee's rights and duties shall be given as soon after the occurrence of the injury as is practicable.

(d) The employer's duty under subsection (a) shall be evidenced by the employee's written acknowledgment of having been informed of and having understood the notice of the employee's rights and duties. Any failure of the employer to provide [and evidence] the notification relieves the employee from any duties specified in the notice, and the employer remains liable for all treatment rendered to the employee. However, an employee may not refuse to sign an acknowledgment to avoid duties specified in the notice.

Subchapter E. MEDICAL TREATMENT REVIEW

UR — GENERAL REQUIREMENTS

§ 127.801. Review of medical treatment generally.

(a) Throughout this subchapter the words "insurer" and "employer" shall be used interchangeably.

(b) UR may be requested by or on behalf of the insurer or employee.

(c) UR may be filed by a provider on behalf of an employee who seeks medical treatment from that provider.

(d) A provider, employee or insurer that seeks or is subject to UR shall be a party to the UR.

(e) UR of medical treatment shall be conducted only by organizations authorized as UROs by the Secretary under § 127.1050 (relating to authorization of UROs/PROs).

(f) The Bureau will return any request for UR which is incomplete or on which the proof of service has not been signed.

(g) A party aggrieved by a UR determination may file a petition for review of UR, to be heard and decided by a workers' compensation judge under §§ 127.901 – 127.906 (relating to UR – petition for review).

§ 127.802. Treatment subject to review.

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

§ 127.803. Assignment of cases to UROs.

(a) The Bureau will assign requests for UR to authorized UROs.

(b) The Bureau will not assign and will return requests for UR of treatment that is already under review at the time of filing or which is subject to an effective determination, recertification or redetermination under § 127.818 (relating to continuing effect of UR determinations).

§ 127.804. Prospective, concurrent and retrospective review.

UR of treatment may be prospective, concurrent or retrospective.

§ 127.805. Requests for UR — filing and service.

(a) A party seeking UR of treatment rendered under the act shall file the Bureau-prescribed form.

(b) The request for UR shall be served on all parties and their known counsel.

(c) The filing party shall complete the proof of service on the form.

(d) Requests for UR shall be sent to the Bureau at the address listed on the form or filed electronically as the Bureau may permit.

(e) The Bureau will not accept and will return UR requests where it can determine any of the following:

(1) The UR requests review of treatment addressed by a previous UR determination.

(2) The UR request is not complete.

(3) The UR request was not served on all parties to the request.

(4) The treatment under review was not treatment for purposes of this chapter.

(5) The request does not identify all providers who rendered care to the injured employee for the work injury.

(6) The provider indicated as the provider under review did not provide health care services to the employee or is not a provider under this chapter.

(f) An insurer's obligation to pay medical bills under § 127.208 (relating to time for payment of medical bills) shall be tolled only when a proper request for UR has been filed with and accepted by the Bureau in accordance with this subchapter.

§ 127.805a. UR of medical treatment prior to acceptance of claim.

(a) The insurer shall pay for treatment found to be reasonable or necessary under § 127.208 (relating to time for payment of medical bills).

(b) Where an insurer requests UR but has not filed documents with the Bureau admitting liability for a work-related injury, or is not subject to a determination imposing this liability, it may not later disclaim liability for the treatment under review in the request for UR.

§ 127.806. Requests for UR — assignment by the Bureau.

(a) The Bureau will 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 all of the following:

(1) The URO.

(2) The employee.

(3) The insurer.

(4) All of the providers under review.

(5) The attorneys for all of the parties, if known.

§ 127.807. Requests for UR — reassignment.

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

(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 under § 127.808 (relating to requests for UR — conflicts of interest).

(d) A URO shall be deemed to have received a Notice of Assignment on the date that the Bureau transmits the notice to the URO by electronic means or by facsimile.

§ 127.808. Requests for UR — conflicts of interest.

(a) A URO shall have a conflict of interest and shall return a request for UR to the Bureau for reassignment if any 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, except as permitted by § 127.819 (relating to requests for UR – recertification) and § 127.820 (relating to requests for UR – redetermination).

(2) The URO has provided case management services in a matter involving the patient whose treatment is under review.

(3) The URO has provided vocational rehabilitation services in a matter involving the patient whose treatment is under review.

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

(5) The URO has assigned utilization review or peer review matters to the provider under review in the provider's capacity as a reviewer.

§ 127.809. Requests for UR — withdrawal.

(a) A party may withdraw a request for UR by notifying the Bureau, in writing, that it seeks to withdraw the request for UR. A party may not send the withdrawal notification directly to the URO.

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

(c) The insurer shall pay the costs of the withdrawn UR.

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

UR -- ENTIRE COURSE OF TREATMENT

§ 127.810. UR of entire course of treatment.

(a) An insurer may request UR of the entire course of treatment rendered to the employee, regardless of the license or specialty of the providers rendering the treatment. This UR shall be retrospective, concurrent and prospective.

(b) An insurer shall make payment for all related medical bills issued more than 30 days before the date the UR request is filed with the Bureau under § 127.208 (relating to time for payment of medical bills).

(c) In response to requests under this section, the URO shall assign each portion of the review rendered by each provider to a reviewer having the same professional license and specialty as the provider rendering treatment to the employee. An inconsistency between reviewers regarding treatment rendered by differently licensed or specialty providers shall be resolved by the URO through consultation of the involved reviewers.

UR -- PRECERTIFICATION

§ 127.811. Pre-certification.

An employee or provider may seek precertification of treatment that has not yet been provided. If a request for precertification of the same treatment is filed by both a provider and employee, the Bureau will consolidate the requests as if a single request had been filed.

§ 127.812. Pre-certification – insurer obligations.

(a) Treatment that has not yet been rendered may be pre-certified as reasonable and necessary in response to a request for prospective UR. Before requesting pre-certification, the parties shall complete all of the following:

(1) The employee or provider seeking pre-certification of treatment shall submit a Bureau-prescribed form to the insurer. The form shall contain a request for pre-certification of treatment, and the employee or provider shall, on the form, specifically identify the treatment for which pre-certification is requested.

(2) The insurer shall respond by completing and returning the form to the employee and provider listed on the form within 10 days of the date upon which the form was mailed. The provider or employee may evidence the date of mailing through the use of the United States Postal Service Form 3817 (Proof of Mailing).

(b) If the insurer responds that it is willing to pay for the treatment, the Bureau will not process any request for pre-certification of the treatment. After the treatment has been provided, the insurer may not request, and the Bureau will not assign, a retrospective UR regarding the same treatment. The insurer shall pay for the treatment as if there had been an uncontested UR determination finding that the treatment was reasonable and necessary.

(c) If the insurer declines to pay for the treatment, the insurer shall indicate the reasons for its denial as set forth on the Department-designated form. If no reasons are indicated on the form, or if the insurer has failed to return the form to the employee or provider within the 10 days under subsection (a)(2), the insurer shall pay for the treatment.

(d) If the insurer denies a causal relationship between the work-related injury and the treatment or denies liability for the work injury on the form, the Bureau will not process a request for pre-certification. The provider or employee may re-file the request when the underlying liability is accepted by the insurer or determined by a workers' compensation judge. If a workers' compensation judge determines that the insurer improperly denied the existence of a causal relationship or liability for the injury, penalties may be assessed under section 435 of the act (77 P.S. § 501). In determining whether the underlying liability has been accepted or determined, the Bureau may utilize information contained in its official records.

(e) If the insurer does not agree to pay for the treatment but does not contest liability or causation, the provider or employee may file a request for pre-certification with the Bureau.

(f) An insurer's denial of payment for treatment later determined to be reasonable and necessary may result in the imposition of penalties under section 435 of the act.

§ 127.813. Pre-certification – provider-filed requests.

(a) A provider filing a request for pre-certification shall detail the treatment plan, procedure or referral that is the subject of the request on or in an attachment to the form.

b) If the provider seeks pre-certification of a referral, the provider shall serve a copy of the request on the provider to whom the referral will be made.

c) The Bureau may return a request that fails to comply with the requirements of this subchapter.

§ 127.814. Pre-certification -- employee-filed requests.

(a) Where an employee seeks pre-certification of treatment, the employe shall identify the provider who may provide the treatment under review. The assigned URO shall contact the provider identified by the employe. The URO shall contact the provider in writing and shall request that the provider submit the treatment plan, procedure or referral for the treatment under review within 10 days of the request.

(b) A provider's failure to timely supply information under this section shall result in a determination that the treatment under review is unreasonable and unnecessary.

§ 127.815. Assignment of proper requests for pre-certification.

If the Bureau determines that the requester is entitled to request pre-certification, the Bureau will assign the request to a URO in accordance with this chapter. The Bureau's assignment or non-assignment of a UR to a URO under this section is interlocutory and is subject to appeal only after the UR determination is rendered. An appeal shall be permitted under § 127.901 (relating to petition for review of UR determination).

PROSPECTIVE, CONCURRENT AND RETROSPECTIVE UR

§ 127.816. Prospective, concurrent and retrospective UR – insurer requests.

(a) An insurer may request review of treatment that the employee is currently undergoing or may undergo in the immediate future.

(b) If the Bureau determines that the requester is entitled to request UR, the Bureau will assign the request to a URO in accordance with this chapter. The Bureau's assignment or non-assignment of a UR to a URO under this section is interlocutory and is subject to appeal only after the UR determination is rendered. An appeal shall be permitted under § 127.901 (relating to petition for review of UR determination).

§ 127.817. Concurrent and retrospective UR -- payment obligations.

(a) An insurer shall make payment for all related medical bills issued more than 30 days before the date the UR request is filed with the Bureau under § 127.208 (relating to time for payment of medical bills).

(b) If the insurer is contesting liability for the work injury, the 30 days in which to request retrospective UR is tolled pending the insurer's acceptance of liability or a workers' compensation judge's determination of liability.

§ 127.818. Continuing effect of UR determinations.

(a) A determination that prospective treatment is reasonable and necessary remains effective for continuing treatment only to the extent specified in the determination.

(b) An employee or provider who was a party to a determination granting pre-certification of treatment may request that the treatment be recertified as reasonable and necessary as permitted by § 127.819 (relating to requests for UR -- recertification).

(c) A determination that treatment is unreasonable or unnecessary remains effective for all treatment found unreasonable or unnecessary, regardless of the provider who renders the treatment, until the employee demonstrates that a change in the employee's medical condition merits re-determination of the treatment.

(d) An employee or provider may request re-determination of treatment previously determined to be unreasonable or unnecessary under § 127.820 (relating to requests for UR – re-determination) if a change in the employee's medical condition has altered the reasonableness or necessity of treatment.

REQUESTS FOR UR – RE-CERTIFICATION AND RE-DETERMINATION

§ 127.819. Requests for UR –recertfication.

(a) If a request for UR resulted in a determination that treatment was or is reasonable and necessary, the employee or provider may request that the treatment be recertified as reasonable and necessary.

(b) The Bureau will not accept a request for recertification submitted more that 30 days before the expiration of a preceding UR or recertification relating to the same treatment.

(c) The Bureau will assign requests for recertification of treatment to the URO that previously determined that treatment was reasonable and necessary.

§ 127.820. Requests for UR – re-determination.

(a) If a request for UR resulted in a determination that prospective treatment is unreasonable or unnecessary, the employee or provider who was a party to the determination may request a re-determination of the treatment upon evidence that the employee's medical condition has changed and the treatment is now reasonable and necessary.

(b) Re-determination shall only be permitted where medical records of treatment occurring since the initial determination demonstrate that the employee's medical condition has changed.

(c) A re-determination under this section shall be prospective in effect and only address treatment rendered after the initial determination.

(d) The Bureau will assign requests for re-determination to the URO that rendered the initial determination that care was unreasonable or unnecessary. The assigned reviewer will determine if the employee's medical condition has changed and the treatment under review is now reasonable and necessary.

URO OPERATIONS

§ 127.821. Requesting and providing medical records.

(a) A URO shall request records from the treating providers listed on the request for UR within 5 days of the date of the Notice of Assignment.

(b) Within 5 days of the date of the Notice of Assignment, the URO shall request that the provider under review provide a complete set of records relating to the work injury. The URO shall submit the request to the provider by certified mail.

(c) The provider under review shall mail all requested medical records to the URO within 15 days of the postmark date of the URO's request.

(d) Upon a URO's request for medical records under § 127.819 (relating to requests for UR – recertification) and § 127.820 (relating to requests for UR – redetermination), the provider under review shall mail all requested medical records to the URO within 7 days of the postmark date of the URO's request.

§ 127.822. Scope of review of UROs.

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

(b) UROs shall decide the extent to which treatment subject to concurrent or prospective review will remain reasonable and necessary in the future.

(c) UROs may not decide, and reviewers may not comment upon, any of the following issues:

(1) The causal relationship between the treatment under review and the employee's work-related injury.

(2) Whether the employee is still disabled.

(3) Whether maximum medical improvement has been obtained.

(4) Whether the provider under review performed the treatment under review as a result of an unlawful self-referral.

(5) The reasonableness of the fees charged by the provider under review.

(6) The appropriateness of the diagnosis, or 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, except as provided in § 127.820 (relating to requests for UR – re-determination).

§ 127.823. Extent of review of medical records.

To determine the reasonableness or necessity of the treatment under review, UROs shall attempt to obtain for review all available medical records of all treatment rendered by all providers to the employee for the work-related injury.

§ 127.824. 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 sent by certified mail, return receipt requested.

(b) The provider under review, or his agent, shall sign a verification stating that to the best of the provider's knowledge, the medical records provided constitute the true and complete medical record as it relates to the employee's work injury. Where records are not accompanied by the appropriate verification, the URO shall return the records to the provider, shall not consider the records in issuing its determination, and shall disregard the fact that the records were forwarded to the URO.

§ 127.825. Employee personal statement.

(a) The employee may submit a statement regarding the reasonableness and necessity of the treatment under review.

(b) Within 5 days of the date of the Notice of Assignment, the URO shall provide written notification to the employee that the employee may submit a statement regarding the reasonableness and necessity of the treatment under review within 15 days of the date of the URO's written notice.

(c) Within 15 days of the date of the written notice referenced in subsection (b), the employee may submit to the URO a personal statement regarding the

reasonableness and necessity of treatment. The personal statement shall meet all of the following conditions:

(1) It may contain only discussion of treatment that the injured employee has received or is receiving from the provider under review.

(2) It may not contain discussion of an independent medical examination or impairment rating evaluation that the injured employee may have had.

(3) It may not contain discussion of a workers' compensation judges' decisions or legal, payment or claims issues.

(4) It may not contain enclosures, attachments or documentation.

(5) It may identify providers who treated the employee for the work injury which were not identified on the request for UR.

(6) It shall be signed by the injured employee.

(d) The URO shall redact any portion of the employee's statement that provides information prohibited under subsection (c) before sending the statement to the reviewer. The URO or the reviewer may not use any information prohibited under subsection (c) in formulating a determination.

(e) The URO and reviewer may utilize the employee's statement in formulating a report and determination subject to the restrictions of this subchapter.

§ 127.826. Insurer submission of studies.

Within 10 days of the date of the Notice of Assignment, the insurer may submit peer-reviewed, independently funded studies and articles and reliable medical literature which are relevant to the reasonableness and necessity of the treatment under review to the URO.

§ 127.827. Obtaining medical records — other treating providers.

(a) A URO shall request medical records from other treating providers in writing.

(b) A provider or his agent who supplies medical records to a URO under this section shall sign a verification stating that to the best of the provider's knowledge the medical records provided constitute the true and complete medical chart as it

relates to the employee's work injury. Where records are not accompanied by the appropriate verification, the URO shall disregard the records and return the records to the provider.

§ 127.828. Obtaining medical records — independent medical exams.

A URO may not request and a party may not supply reports of examinations or evaluations performed at the request of an insurer, employee or attorney for the purposes of litigation. Only the medical records of actual treating providers, and the personal statement and studies referenced in § 127.825 (relating to employee personal statement) and § 127.826 (relating to insurer submission of studies), may be requested by or supplied to a URO.

§ 127.829. Obtaining medical records — duration of treatment.

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

§ 127.830. Obtaining medical records — reimbursement of costs of provider.

(a) A provider seeking reimbursement of copying and postage costs shall submit an itemized bill for the copying and postage costs to the URO.

(b) Within 30 days of receiving medical records, the URO shall reimburse the provider for the requested record-copying costs at the rate specified by Medicare and for actual postage costs. The Bureau will publish changes to the Medicare rate in the *Pennsylvania Bulletin*.

(c) Reproduction of radiologic films shall be reimbursed at the usual and customary charge. The cost of reproducing the films shall be itemized separately in the URO's bill for performing the UR.

§ 127.831. Provider under review's failure to supply medical records.

(a) If the provider under review fails to mail medical records to the URO within 15 days of the date of the URO's request for the records under § 127.821 (relating to requesting and providing medical records), the URO shall render a determination that the treatment under review is unreasonable and unnecessary.

(b) A provider's failure to supply records under this section shall constitute a waiver of its opportunity to participate in the UR process relating to the treatment under review.

(c) A provider that fails, without reasonable cause or excuse, to supply records under this section may not introduce evidence regarding the reasonableness and necessity of the treatment in an appeal under § 127.901 (relating to petition for review of UR determination).

§ 127.832. Requests for UR — deadline for URO determination.

(a) A request for UR shall be deemed complete upon the URO's receipt of the medical records or 18 days from the date of the notice of assignment, whichever is earlier.

(b) A URO shall complete its review and render its determination within 20 days of a completed request for UR except as provided in subsection (c).

(c) A URO shall complete its review and render its determination with 10 days of a completed request for UR filed under § 127.819 (relating to request for UR – recertification) and § 127.820 (relating to request for UR – re-determination).

§ 127.833. Assignment of UR request to reviewer.

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

(b) The URO shall redact any material that does not reflect the evaluation and treatment of the patient before forwarding the material to the reviewer. The URO shall forward only medical records and documentation required by this subchapter to the assigned reviewer.

§ 127.834. Duties of reviewers — generally.

(a) A reviewer shall issue reports that address the reasonableness and necessity of the treatment under review by reference to the best available clinical evidence regarding the treatment. The reviewer shall apply generally accepted treatment

protocols, independently funded peer-reviewed studies and articles, and reliable medical literature appropriate for the review. The reviewer shall specifically reference the protocols, studies, articles and literature in the reviewer's report.

(b) A reviewer shall decide only the issue of whether the treatment under review is reasonable or necessary for the diagnosis of the employee, as rendered by the provider under review.

(c) A reviewer shall assume the existence of a causal relationship between the treatment under review and the employee's work-related injury. The reviewer may not consider or comment upon whether the employee is still disabled, whether maximum medical improvement has been obtained, quality of care, reasonableness of fees or an issue that is not directly relevant to the reasonableness and necessity of treatment rendered to the employee.

(d) In a determination in which the reviewer determines that prospective treatment is reasonable and necessary, the reviewer shall clearly provide a timeframe not to exceed 180 days within which such treatment remains reasonable and necessary. The review shall specifically cite to generally accepted treatment protocols, independently funded peer-reviewed studies and articles, and reliable medical literature that support the determination and the timeframe in question.

(e) A reviewer shall make a definite determination as to whether the treatment under review is reasonable or necessary. A reviewer may not render advisory opinions regarding whether additional diagnostic tests are needed. In determining whether the treatment under review is reasonable or necessary, a reviewer may consider whether other courses of treatment exist. A reviewer may not determine that the treatment under review is unreasonable or unnecessary solely because other courses of treatment exist.

(f) If the reviewer is unable, after reviewing all relevant information, to determine whether the treatment under review is reasonable or necessary, the reviewer shall resolve the issue in favor of the provider under review.

§ 127.835. Duties of reviewers — conflict of interest.

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

(1) The reviewer has a previous involvement with the patient or with the provider under review regarding the same underlying claim except as

permitted by § 127.819 (relating to requests for UR – re-certification) and § 127.820) (relating to requests for UR – re-determination).

(2) The reviewer has provided case management services in a matter involving the patient whose treatment is under review.

(4) The reviewer has provided vocational rehabilitation services in a matter involving the patient whose treatment is under review.

(5) The reviewer has a contractual relationship with a party in the matter.

§ 127.836. Duties of reviewers — content of reports.

A reviewer's written report shall contain all of the following elements:

(1) A listing of the medical records reviewed.

(2) The reviewer's findings and conclusions.

(3) A detailed explanation of the reasons for the conclusions reached by the reviewer. The explanation shall cite all applicable generally accepted treatment protocols, independently funded peer-reviewed studies and articles, and reliable medical literature used to support the determination and timeframe under review.

§127.837. Duties of reviewers — signature and verification.

(a) A reviewer shall sign a report. A signature stamp may not be used.

(b) A reviewer 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.

§ 127.838. Duties of reviewers — forwarding report and medical records to URO.

A reviewer shall forward a report and all medical records reviewed to the URO upon completion of the report.

§ 127.839. Duties of UROs –review of report.

(a) A URO shall examine the reviewer's report to ensure that the reviewer has complied with the requirements of this subchapter.

(b) A URO 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.

§ 127.840. Form and service of determinations.

(a) A determination rendered by a URO shall include a medical treatment review determination face sheet on a Bureau-prescribed form and include the reviewer's report. An authorized representative of the URO shall sign the determination face sheet.

(b) When a determination is rendered against the provider under review because the provider under review failed to comply with § 127.821 (relating to requesting and providing medical records), the determination shall consist only of the face sheet. The face sheet shall state that the basis for the decision is the provider under review's failure to supply medical records to the URO.

(c) The URO shall serve the determination upon the Bureau, all parties identified on the Notice of Assignment and their attorneys, if known.

(d) The URO shall serve a copy of a "Petition for Review of Utilization Review Determination" on all parties identified on the Notice of Assignment and their attorneys, if known.

§ 127.841. Determination against insurer — payment of medical bills.

(a) 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).

(b) Interest continues to accrue under section 306 (f.1)(1) of the act (77 P.S. § 511 (1)) during the UR process. The insurer shall pay interest on bills for treatment that is eventually determined to be reasonable and necessary. The filing of a request for UR tolls the payment requirements of § 127.208 only during the consideration of UR. The insurer's failure to timely pay any amount due under

this section may result in the imposition of penalties under section 435 of the act (77 P.S. § 991).

UR — PETITION FOR REVIEW

§ 127.901. Petition for review of UR determination.

A party aggrieved by a UR determination may file a "Petition for Review of Utilization Review Determination."

§ 127.902. Petition for review — time for filing.

The petition for review shall be filed with the Bureau within 30 days of the date of the URO's determination.

§ 127.903. Petition for review — notice of assignment and service.

(a) The Bureau will assign the petition for review to a workers' compensation judge when there is a UR determination relating to the petition for review.

(b) The Bureau will mail the notice of assignment and the petition for review to the URO, the employee, the insurer, the provider under review, and the attorneys for the parties, if known. The Bureau may mail the notice of assignment to other providers listed on the request for UR.

§ 127.904. Petition for review — no answer allowed.

The Bureau will not accept an answer to the petition for review.

§ 127.905. Petition for review— transmission of records

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

(b) 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 medical records within 10 days of the date of the workers' compensation judge's order.

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

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

§ 127.906. Petition for Review by Bureau —hearing and evidence.

(a) The hearing before the workers' compensation judge shall be a *de novo* proceeding.

(b) The URO report shall be part of the record before the workers' compensation judge and the workers' compensation judge will consider the report as evidence.

(c) The workers' compensation judge will not be bound by the URO report. The workers' compensation judge may request additional review of the treatment under review under section 420 of the act (77 P.S. § 831).

(d) The workers' compensation judge may disregard evidence offered by any party who has failed to respond to a URO's request for records in the same UR matter, as set forth in § 127.831 (relating to provider under review's failure to supply records).

PEER REVIEW

§ 127.1001. Peer review — availability.

(a) A workers' compensation judge may, on the workers' compensation judge's own motion or upon the motion of any party, 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) The opinion is necessary or appropriate in other litigation proceedings before the worker's compensation judge. Peer review is not necessary or appropriate if there is a pending UR of the same treatment.

(b) A workers' compensation judge is not required to grant a party's motion for peer review under subsection (a).

§ 127.1002. Peer review — procedure upon motion of party.

(a) A party may not file a request for UR while a motion for peer review regarding the same treatment is pending.

(b) If the workers' compensation judge does not rule on the motion for peer review within 10 days, the motion shall be deemed denied.

(c) If the motion for peer review is denied, a party may file requests for UR as permitted in this subchapter.

(d) If the motion for peer review is granted, the workers' compensation judge will proceed under § 127.1004 (relating to peer review — forwarding request to Bureau).

§ 127.1003. Peer review — interlocutory ruling.

The ruling on a motion for peer review is interlocutory.

§ 127.1004. Peer review — forwarding request to Bureau.

(a) A workers' compensation judge may request peer review by submitting a request to the Bureau on a Bureau-prescribed form. The workers' compensation judge will serve a copy of the request upon all parties and their attorneys, if known.

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

§ 127.1005. Peer review — assignment by the Bureau.

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

(b) The Bureau will send a Notice of Assignment of Peer Review to the PRO, the workers' compensation judge, all parties and their attorneys, if known.

§ 127.1006. Peer review — reassignment.

(a) If a PRO is unable to perform a request peer review assigned to it by the Bureau, the PRO shall return the request for peer review to the Bureau for reassignment within 5 days of the PRO's receipt of the Notice of Assignment.

(b) A PRO may not 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 with the request under § 127.1007 (relating to peer review – conflicts of interest).

(d) A PRO shall be deemed to have received a Notice of Assignment on the date that the Bureau transmits the notice to the URO by electronic means or by facsimile.

§ 127.1007. Peer review — conflicts of interest.

A PRO shall have a conflict of interest and shall return a request for peer review to the Bureau for reassignment for any of the following reasons:

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

(2) The PRO has provided case management services in a matter involving the patient whose treatment is under review.

(3) The PRO has provided vocational rehabilitation services in a matter involving the patient whose treatment is under review.

(4) The PRO is owned by or has a contractual arrangement with a party to the review.

(5) The PRO has assigned UR or Peer Review matters to the provider under review in the provider under review's capacity as a reviewer.

§ 127.1008. Peer review — withdrawal.

(a) A request for peer review shall be withdrawn only upon the written order of the workers' compensation judge. The workers' compensation judge will serve a copy of the order upon the Bureau.

(b) The Bureau will promptly notify the PRO of the withdrawal. The Bureau will pay the costs of the peer review from the Workmen's Compensation Administration Fund.

§ 127.1009. 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 to the assigned PRO all medical records received and reviewed for the purposes of the UR.

(b) In all other cases, the PRO shall use the subpoenas supplied under § 127.1004(b) (relating to peer review – forwarding request to Bureau) to obtain medical records from all providers for the entire course of treatment rendered to the employee for the work-related injury. The PRO shall request the medical records within 10 days of the date of the Notice of Assignment.

§ 127.1010. Obtaining medical records — independent medical exams.

A PRO may not request and a party may not supply reports of examinations or evaluations performed at the request of an insurer, employee or attorney for the purposes of litigation. Only the medical records of actual treating providers may be requested by or supplied to a PRO.

§ 127.1011. Provider under review's failure to supply medical records.

(a) If the provider under review fails to comply with a subpoena issued under this subchapter, the PRO shall report the provider's noncompliance to the workers' compensation judge.

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

§ 127.1012. Assignment of peer review request to reviewer by PRO.

Upon receipt of the medical records, the PRO shall forward the medical records, the request for peer review and the Notice of Assignment to a reviewer licensed by the Commonwealth in the same profession and having the same specialty as the providers under review.

§ 127.1013. Duties of reviewers — generally.

A reviewer shall adhere to the requirements of § 127.834 (relating to duties of reviewers – generally).

§ 127.1014. 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 or potentially exist:

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

(2) The reviewer has provided case management services in a matter involving the patient whose treatment is under review.

(4) The reviewer has provided vocational rehabilitation services in a matter involving the patient whose treatment is under review.

(5) The reviewer has a contractual relationship with a party in the matter.

§ 127.1015. Duties of reviewers — finality of decisions.

(a) A reviewer shall make a definite determination as to the necessity and frequency of the treatment under review. A reviewer may not render advisory opinions on whether additional diagnostic tests are needed. In determining whether the treatment under review is necessary, a reviewer may consider whether other courses of treatment exist. However, a reviewer may not determine that the treatment under review is unreasonable or unnecessary solely because other courses of treatment exist.

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

§ 127.1016. Duties of reviewers — content of reports.

A reviewer's written report shall contain all of the following elements:

(1) A listing of the medical records reviewed.

(2) The reviewer's findings and conclusions.

(3) A detailed explanation of the reasons for the conclusions reached by the reviewer. The reviewer shall cite all applicable generally accepted treatment protocols, independently funded peer-reviewed studies and articles, and reliable medical literature used to support the determination and timeframe under review.

§ 127.1017. Duties of reviewers — signature and verification.

(a) A reviewer shall sign a report. Signature stamps may not be used.

(b) A reviewer 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.

§ 127.1018. Duties of reviewers — forwarding report and records to PRO.

A reviewer shall forward the reports and all medical records reviewed to the PRO upon completion of the report.

§ 127.1019. Duties of PRO — review of report.

(a) A PRO shall examine the reviewer's report to ensure that the reviewer has complied with the requirements of this subchapter.

(b) A PRO 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.

§ 127.1020. Peer review — deadline for PRO determination.

A PRO shall complete its review and render its determination within 15 days of its receipt of the medical records.

§ 127.1021. PRO reports — filing with judge and service.

(a) The PRO shall forward its report to the workers' compensation judge.

(b) The PRO shall mail copies of the report by certified mail, return receipt requested, to all parties listed on the Notice of Assignment and their attorneys, if known.

§ 127.1022. PRO reports — evidence.

The PRO report shall be a part of the record of the pending case. The workers' compensation judge will consider the report as evidence but is not bound by the report.

§ 127.1023. PRO reports — payment.

The PRO shall submit a bill for services relating to its review and report to the workers' compensation judge for approval.

URO/PRO Authorization

§ 127.1050. Authorization of UROs/PROs.

(a) The Bureau may authorize UROs/PROs to perform reviews under this chapter through an award of contracts under the Commonwealth Procurement Code. (62

Pa. C.S. §§ 1701-1726) The Bureau will award contracts on a competitive sealed basis in accordance with the Commonwealth Procurement Code.

(b) The request for proposal (RFP) issued by the Bureau will set forth the specific minimum requirements that an offeror's proposal must address The RFP shall require the offeror to describe the specific means by which it will conduct UR/Peer Review operations and comply with this chapter and any other information that the BWC may request. Proposals must demonstrate that the offeror has the ability to meet the requirements set forth in this chapter.

(c) The Bureau is not required to award a contract to every offeror that submits a proposal that meets the minimum requirements established by the RFP.

§ 127.1051. UROs/PROs authorized prior to (the effective date of these amendments).

UROs/PROs authorized before (the effective date of this proposed rulemaking) shall continue to be authorized until the expiration date set forth on the authorization issued by the Bureau.

DEPARTMENT OF
LABOR & INDUSTRY
COMMONWEALTH OF PENNSYLVANIA

THE SECRETARY
ROOM 1700, LABOR & INDUSTRY BUILDING
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May 26, 2006

The Honorable Alvin C. Bush, Chairman
Independent Regulatory Review Commission
14th Floor, Harristown 2
333 Market Street
Harrisburg, PA 17101

Re: Proposed Rulemaking
Department of Labor & Industry
Medical Cost Containment, No. 12-72

Dear Chairman Bush:

Enclosed please find a proposed rulemaking package consisting of a face sheet, preamble, annex and regulatory analysis form prepared by the Department of Labor and Industry. The rulemaking will update and clarify provisions for the treatment of work-related injuries in the workers compensation system, and payment for such treatment. Specifically, it will establish systems of medical fee caps, review of utilization of medical treatment, and review of medical coding and fees. The workers' compensation community relies on these regulations to provide guidance for medical billing procedures, to publish established medical fees, to resolve fee disputes, and to resolve disputes regarding the reasonableness and necessity of medical treatment through utilization review.

The proposed rulemaking will amend the Pennsylvania Code (34 Pa. Code, Chapter 127).

Written comments, suggestions or questions should be directed to Eileen K. Wunsch, Chief, Health Care Services Division, Bureau of Workers' Compensation, P.O. Box 15121, Harrisburg, PA 15121 (Telephone: 717-783-5421; Fax: 717-772-0342; Email: ra-li-bwc-administra@state.pa.us).

The Department's staff will provide your staff with any assistance required to facilitate your review of this proposal.

Sincerely,

Stephen M. Schmerin

Enclosure

TRANSMITTAL SHEET FOR REGULATIONS SUBJECT TO THE REGULATORY REVIEW ACT

I.D. NUMBER:	12-72
SUBJECT:	Medical Cost Containment
AGENCY:	DEPARTMENT OF LABOR & INDUSTRY

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
5/26/06	B. Dypaul	HOUSE COMMITTEE ON LABOR RELATIONS
5/26	Danielle Tomlanchi	
5/26	Mandi Laufer	SENATE COMMITTEE ON LABOR & INDUSTRY
5/26	Buck Lu	
5/26	J. Gelnett	INDEPENDENT REGULATORY REVIEW COMMISSION
		ATTORNEY GENERAL (for Final Omitted only)
5/24	C. Lee Ryan	LEGISLATIVE REFERENCE BUREAU (for Proposed only)

May 17, 2006