PROPOSED RULEMAKING

DEPARTMENT OF LABOR AND INDUSTRY

[34 PA. CODE CHS. 123 AND 127]
General Provisions of Act 57 of 1996

The Department of Labor and Industry (Department), Bureau of Workers' Compensation (Bureau), proposes to provide clarifications and detailed guidance for the uniform application of the provisions of the act of June 24, 1996 (P. L. 350, No. 57) (Act 57), which amended the Workers' Compensation Act (act) (77 P. S. §§ 1— 2626). Chapter 123 (relating to general provisions—Part II) proposed to be added. In addition, because Act 57 abrogated the reconsideration stage of the utilization review (UR) process, the Department proposes to repeal and amend certain portions of Chapter 127 (relating to workers' compensation medical cost containment). Specifically, the Department proposes the deletion of §§ 127.501—127.515 (relating to UR—reconsideration). The Department also proposes to delete language throughout Chapter 127 which references both the initial and reconsideration stages of UR. Additionally, the Department proposes to amend § 127.105 (relating to outpatient providers subject to Medicare fee schedule—chiropractors) due to changes in the Medicare fee schedule relating to the reimbursement of chiropractic treatment. The procedural code A2000 under the Medicare Fee Schedule has been repealed and replaced effective January 1, 1997; therefore, reimbursement of chiropractors is to be governed by the new procedure codes. Further, the Department proposes to amend: (1) § 127. 251 (relating to Medical fee disputes—review by the Bureau) to incorporate the statute of limitations imposed on providers wishing to file applications for Medical Fee Review under Act 57; (2) § 127.452 (relating to initial requests for UR—filing and service) to clarify who the provider under review is when a UR request is filed; (3) § 127.751 (relating to employer's option to establish a list of designated health care providers); (4) § 127.752 (relating to contents of list of designated health care providers); and (5) § 127.755 (relating to required notice of employe rights and duties). The amendments to §§ 127.751, 127.752 and 127.755 are proposed so as to incorporate the amendments of Act 57 which permit the inclusion of four Coordinated Care Organizations (CCOs) on the employer's list of designated providers and which require an employe to treat with an employer-designated provider for 90 days, and which may require continued treatment for an additional 90 days when an employer-designated physician recommends invasive surgery for the employe.

Statutory Authority

These amendments are proposed under the authority provided in sections 401.1 and 435 of the act (77 P. S. §§ 710 and 991) which provide that the Department adopt regulations which are necessary or desirable for the enforcement of the act and which are reasonably calculated to provide interested parties of their rights under the act. These amendments are proposed under the additional authority of sections 204(d) and 306(f.2)(7) of the act (77 P. S. §§ 71 and 511.2(f.2)(7)), which charge the Department with establishing regulations implementing those sections which govern the offset of workers' compensation benefits by amounts received in unemployment compensation, Social Security (old age) benefits, severance and pension benefits and the certification of CCOs.

Background

On June 24, 1996, Governor Tom Ridge signed into law Act 57, which substantially amended the act. The amendments are intended to address the rising costs of workers' compensation in this Commonwealth while preserving the rights of employes to be adequately compensated for their work-related injuries. Among the amendments are provisions which allow an executive officer of a nonprofit corporation to elect not to be an employe for the purposes of workers' compensation coverage, provisions which allow the offset of workers' compensation benefits from certain amounts received from Social Security (old age), severance and pension benefits, and provisions which require that, in order for an employer's spouse or child to be deemed an employe for purposes of workers' compensation coverage, an employer of agricultural labor shall file an express written contract for hire with the Department. The amendments also call for the abrogation of the reconsideration stage of the UR process and the placement of time limitations on health care providers wishing to file applications for medical fee review. The amendments also require that an employe's earning power be determined by expert opinion, and that the Department establish the qualifications of vocational experts. Further, Act 57 provides for an impairment rating evaluation after the receipt of 104 weeks of total disability compensation. If the impairment rating is less than 50%, the employe's benefit status shifts from total to partial disability with benefits capped at 500 weeks. In addition, Act 57 establishes an automatic request for supersedeas when a petition alleging an employe's full recovery is filed accompanied by a physician's affidavit to that effect.

Act 57 added two sections to the act which address situations in which employes who have returned to work are receiving both wages and workers' compensation benefits. These sections call for the suspension or modification of benefits after notice and an affidavit are submitted which allege that the employe has returned to work. Act 57 also places new reporting requirements on employes who file for (or are receiving) compensation under section 306(a) or (b) of the act. Employes are required to regularly report amounts received from unemployment compensation, Social Security (old age), severance and pension benefits. Additionally, employes are required to report information regarding employment and self-employment, as well as any other information which is relevant in determining the entitlement to or amount of compensation. Further, insurers are permitted to submit forms to employes in order for employes to provide verification that the employes' status regarding their entitlement to receive workers' compensation benefits has not changed. Act 57 also created an informal conference procedure to expedite the workers' compensation adjudication process, and a process by which employers and employes can enter into Compromise and Release Agreements which may extinguish the employer's liability for a work-related injury. Act 57 permits an employer and the recognized or certified exclusive representatives of its employes to bargain collectively over specified issues relating to workers' compensation in order to facilitate the resolution of claims. In an effort to promote workplace safety and reduce employe injuries and employer costs, Act 57 granted a 5% premium discount to employers with

Department-certified safety committees for a maximum period of 5 years. Act 57 also increased penalties as a result of unreasonable or excessive delays.

Act 57 amended section 306(f.2) of the act by transferring the authority for certification of CCOs from the Department of Health to the Department. Accordingly, the Department will develop procedures and issue an application form for CCO certification. CCOs currently certified by the Department of Health will continue to be certified until the new procedures for CCO certification are published in the *Pennsylvania Bulletin*. Section 31.2 of Act 57 provides that the regulations promulgated by the Department of Health under section 306(f.2)(7) of the act shall be deemed regulations of the Department. The Department intends to operate under the existing statement of policy published by the Department of Health in 28 Pa. Code Chapter 9, Subchapter B (relating to coordinated care organizations—statement of policy).

Since the passage of Act 57 and the publication of the Department's notice at 26 Pa. B. 3979 (August 17, 1996), the Department has received various written and verbal comments regarding the interpretation of various provisions of Act 57. Additionally, consistent with the Governor's policy, as set forth in Executive Order 1996-1, the Department has consulted with stakeholders affected by the passage and implementation of Act 57. In addition to the stakeholders, the Department considered the comments and suggestions made by members of the Pension and Independent Medical Examination (IME) Task Forces, as well as the section 450 subcommittee to the Governor's Committee on Labor-Management Partnerships, organized to lend interpretive guidance on the implementation of sections 204, 306(a.2) and 450 of the act respectively.

The Department published a statement of policy at 27 Pa.B. 1731 (April 5, 1997) in an effort to provide interpretive guidance to all parties of their rights and obligations under Act 57. The statement of policy was written in the spirit of implementing the Legislative intent of achieving the greatest cost savings in amounts paid in workers' compensation premiums, benefits payments and litigation costs, while preserving the rights of employes to be adequately compensated for their work-related injuries. The statement of policy invited all interested parties to provide written comments to the Bureau. Written comments received were considered in the promulgation of these proposed amendments.

This notice of proposed rulemaking further clarifies and expands upon the previous interpretation of Act 57 provided in the statement of policy. In response to comments received and stakeholder meetings, some changes have been made to the interpretations published on April 5, 1997. The Department intends to delete the statement of policy which appears in Chapter 122 (relating to general provisions of Act 57 of 1996—statement of policy) when the proposed addition of Chapter 123 is adopted.

Purpose

The purpose of these proposed amendments is to effectuate the provisions of Act 57. The amendments at sections 204; 306(a.2); (b)(2) and (3), (f.1)(1)(i) and (f.1)(5); 311.1; 402.1; 413(a.1), (c) and (d); and 450 were intended to curtail the escalating costs associated with work-related injuries, while preserving the right of injured workers to be adequately compensated for their work-related injuries. Generally, these cost savings are effectuated through the offset of workers' compensation benefits by amounts received by employes in unemployment compensation, Social Security (old age), severance and pension benefits; the abrogation of the reconsideration stage of the UR process and the placement of time limitations on health care providers for the filing of applications for medical fee review; the addition of an impairment rating evaluation after the employe's receipt of 104 weeks of total disability benefits in order to determine the percentage of whole body impairment; the addition of new employe reporting requirements; and the allowance of collective bargaining over certain issues relating to workers' compensation benefits and the compromise and release of claims.

Since the passage of Act 57, interested parties have expressed their desire for the expeditious promulgation of regulations to provide definitive interpretations and guidance in order that all parties have a clear understanding of their rights and obligations under the Act 57 amendments. These proposed amendments provide the guidance needed to ensure consistent application and compliance with Act 57.

Affected Persons

Those affected by these proposed amendments are private and public sector employers in this Commonwealth, workers' compensation insurance carriers, self-insured employers, health care providers and injured workers.

Fiscal Impact

There is no significant fiscal impact associated with this proposed rulemaking. Although Act 57 required the creation of new Departmental forms for public use, most of these forms were created prior to the effective date of Act 57, therefore, significant costs are not expected. Furthermore, any costs to the regulated community associated with the implementation of these proposed amendments will be offset by the expected savings of Act 57's amendments. Cost savings to the regulated community are estimated at over $225 million for the first policy year which commenced on February 1, 1997. Additionally, any costs to the Commonwealth will be offset by the savings experienced by the Commonwealth as a self-insured employer.

Summary of Proposed Rulemaking. Chapter 123

(1) *Organization of Chapter 123*. These proposed amendments provide detailed guidelines implementing the general provisions of Act 57 relating to workers' compensation. The chapter is divided into ten subchapters, with Subchapter A (relating to offset of unemployment compensation, Society Security (old age), severance and pension benefits) devoted to provisions relating to the offset of workers' compensation benefits by amounts received in unemployment compensation, Social Security (old age), severance and pension benefits. Subchapter B (relating to impairment ratings) details the method of obtaining an impairment rating evaluation and the method for the shift of benefit status from total to partial. Subchapter C (relating to qualifications for vocational experts approved by the Department) establishes the qualifications for vocational experts approved by the Department. Subchapter D (relating to earning power determinations) sets forth employer prerequisites to seeking a modification or suspension of benefits. Additionally, this subchapter sets forth the standard for which an employe's earning power will be determined. Subchapter E (relating to collective bargaining) provides guidance on the use of alternative dispute resolution systems in collective bargaining agreements by an employer and its

organized labor force. Subchapter F (relating to employe reporting and verification requirements) sets forth employe reporting and verification requirements. Subchapter G (relating to special supersedeas) establishes the procedures for automatic requests for supersedeas and return-to-work suspensions and modifications. Subchapter H (relating to informal conferences) clarifies the representation requirements of informal conferences. Subchapter I (relating to use of optically scanned documents) governs the use of optically scanned documents and the admissibility of copies into evidence. Finally, Subchapter J (relating to unreasonable or excessive delays) sets forth the time period for which an employer's delay may be considered unreasonable or excessive in connection with the assessment of penalties.

(2) *Subchapter A. Offset of workers' compensation benefits*

Prior to Act 57, section 204 of the act provided for the offset of workers' compensation benefits by amounts an employe received in unemployment compensation. Act 57 amended section 204 of the act by providing additional offsets for Social Security (old age), severance and pension benefits. While the offset for unemployment compensation benefits applies to all work-related injuries, the offset for Social Security (old age), severance and pension benefits applies only to claims for injuries which are suffered on or after June 24, 1996.

Section 204 of the act requires employes to regularly report the receipt of unemployment compensation, Social Security (old age), severance and pension benefits received subsequent to the date of injury. The report shall be made on Form LIBC-756A, "Employee's Report of Benefits (Unemployment Compensation, Social Security (old age), Severance and Pension Benefits) for Offsets."

Consistent with the Department's statement of policy in § 122.3 (relating to employe report of benefits subject to offset) the proposed amendments interpret the term "regularly" to mean within 30 days of any change in the receipt of the benefits mentioned above, but in any event no less than every 6 months. The proposed amendments provide that the offset shall apply only to wage-loss benefits (as opposed to medical benefits, specific loss or survivor benefits), and that the wage-loss benefits shall be offset by the net amount received by the employe. The net amount is the amount of any unemployment compensation, Social Security (old age), pension or severance benefits received by the employe after the required deductions for local, State and Federal taxes and amounts deducted under the Federal Insurance Contributions Act (FICA) (26 U.S.C.A. §§ 3101—3126).

Unemployment compensation benefits received by an employe are not initially subject to the required deductions for taxes. Accordingly, the net amount of unemployment compensation is determined when employes who have received unemployment compensation benefits file the required tax forms at the end of the tax year. Therefore, insurers who have offset workers' compensation benefits by amounts received in unemployment compensation benefits may be required to reimburse the employe for the amount offset which is attributable to the employe's tax liability. Employes who are required to pay taxes on amounts received in unemployment compensation benefits may notify the insurer of these payments in writing. Insurers are not required to repay an employe until the employe provides this notification.

The proposed amendments provide that after receipt of the completed Form LIBC-756A, an insurer may calculate and achieve the offset of benefits received by the employe from any of the sources enumerated in section 204 of the act. Consistent with the Department's statement of policy in § 122.4 (relating to application of the offset, generally) the proposed amendments provide for a self-executing offset after notification. The insurer shall notify the employe and the employe's counsel, if known, and the Department on Form LIBC-761, "Notice of Workers' Compensation Benefit Offset," that the workers' compensation benefits will be offset. The notice shall be provided to the employe at least 15 days prior to the offset of workers' compensation benefits. This notice shall indicate the amount and type of the offset; how the offset was calculated, with supporting documentation; when the offset commences; and the amount of any recoupment, if applicable. Supporting documentation may include, but is not limited to, any information supplied by employes to insurers by Forms LIBC-756A, "Employee's Report of Benefits (Unemployment Compensation, Social Security (Old Age), Severance and Pension Benefits) for Offsets;" LIBC-750, "Employee Report of Wages (other than Workers' Compensation Benefits Received)"; LIBC-760, "Employee Verification of Employment, Self-employment or Change in Physical Condition."

The employe may challenge the offset by filing a petition for review with the Department. It is the insurer's burden to demonstrate that the notice of worker's compensation benefit offset was received by the employe. The insurer's burden is met if it provides evidence that the notice was mailed to the employe, at the employe's last known address, by first-class mail.

Consistent with the Department's statement of policy in § 122.5 (relating to credit for benefits already received), these proposed amendments provide that in the event the insurer receives information that the employe is receiving or has already received unemployment compensation, Social Security (old age), severance or pension benefits prior to receiving Form LIBC-756A, the insurer shall be entitled to recoup the offset for amounts already received by the employe in a lump-sum manner. This recoupment results in an offset against future payments of workers' compensation benefits until the offset amount has been fully recouped.

Subchapter A provides the manner in which an offset of workers' compensation from amounts received in unemployment compensation, Social Security (old age), severance and pension benefits shall be achieved. These proposed amendments provide the specific methods of calculating the offset dependent upon the type of benefit received by the employe. The offset to workers' compensation benefits shall apply only for amounts an employe receives which are attributable to the same time period in which an employe also receives workers' compensation benefits. The offset is not applicable to any benefit to which an employe may be entitled or eligible, but is not receiving.

The Department created a Pension Task Force to aid in the promulgation of proposed amendments to effectuate the provisions relating to the offset of workers' compensation benefits by amounts received in pension benefits. Consistent with the Department's statement of policy in § 122.8 (relating to Offset of pension benefits, generally), these proposed amendments interpret the term "pension benefits" as benefits received from defined-benefit plans and defined-contribution plans. Further, the definition of pension benefits is to be construed consistently with Title 1 of ERISA. The offset is applicable only to the extent the pension benefit is funded by the employer directly liable for the payment of workers' compensation benefits.

In promulgating these pension offset provisions, the Department attempted to achieve the most favorable result in terms of effectuating the projected savings of this section, while at the same time preserving pension funds which are intended for an employe's retirement. Therefore, these proposed amendments provide that workers' compensation benefits may not be offset by pension benefits which are rolled over into an Individual Retirement Account (IRA) or other similarly restricted account, provided that the employe does not utilize or otherwise withdraw funds from the account while at the same time receiving workers' compensation benefits from the liable employer. However, the Department determined that when the employe receives the pension in the form of a lump-sum payout and is utilizing the pension benefit, the pension offset shall be calculated based upon the actuarial equivalent of the lump sum with respect to the annuity options (qualified joint and survivor annuity or life annuity) available at the time of the employe's receipt. Therefore, the monthly amount the employe would have received from an annuity, had the employe chosen to accept the pension in the form of an annuity, shall be used to calculate the weekly offset amount. The annuity options available at the time of receipt are those options, based upon interest and mortality, which were generally available for purchase by the employe at the time the employe received the pension.

If the employe receives a pension from a multi-employer funded pension plan, the offset shall be calculated based on the proportion of the liable employer's contribution to the pension fund. Contributions from other employers in the multi-employer funded pension plan shall not be included in the offset. Therefore, the "extent funded by the liable employer" shall be obtained by calculating that portion of the annuity which was actually contributed by the employer at the time of the employe's receipt of the pension benefits.

Severance benefits, which are received subsequent to the work-related injury, shall be offset to the extent funded by the employer directly liable for the payment of compensation. Consistent with the Department's statement of policy in § 122.2 (relating to definitions), these proposed amendments define severance benefits as any benefit which is taxable to the employe and which is paid as a result of the employe's separation from employment. Severance benefits include benefits received in the form of tangible property; however, the term may not include earned income, such as payments based on an employe's unused vacation or sick leave.

(3) *Subchapter B. Impairment Ratings*

Section 306 of the act was amended by Act 57 to provide for an impairment rating evaluation (IRE) to determine the percentage of whole body impairment due to the compensable injury at the expiration of an employe's receipt of 104 weeks of total disability compensation. The impairment rating is a mechanism for adjusting the status of workers' compensation benefits between total and partial. As established by the Department's statement of policy in § 122.102 (relating to Impairment rating evaluation requests), and in § 123.102 (relating to impairment rating evaluation requests), an insurer may request an IRE within 60 days of the employe's receipt of 104 weeks of total disability benefits. These proposed amendments interpret this section to allow an insurer to request an evaluation beginning 60 days prior to the expiration of the 104 weeks and continuing up to 60 days after the expiration of the employe's receipt of 104 weeks of total disability benefits. If the evaluation is requested and performed during this time period, the adjustment of disability status shall relate back to the expiration of the employe's receipt of 104 weeks of total disability benefits. In cases where the evaluation takes place more than 60 days past the expiration of 104 weeks, the adjustment of disability status shall be effective as of the date of the evaluation or as determined by the evaluating physician. Absent agreement between the parties, the IRE may not be performed prior to the expiration of the employe's receipt of 104 weeks of total disability benefits.

Consistent with the Department's statement of policy in § 122.103 (relating to physicians), these proposed amendments provide that the physician performing the IRE shall be a physician licensed in this Commonwealth who is certified by an American Board of Medical Specialties-approved board or its osteopathic equivalent and who is active in clinical practice at least 20 hours per week. These proposed amendments interpret the phrase "active in clinical practice" to mean the act of providing preventive care and the evaluation, treatment and management of the medical conditions of patients on an ongoing basis. The Department reserves the right to establish additional requirements for physicians appointed by the Department for purposes of conducting IREs. The Department has established through these proposed amendments a process and time frame for the appointment of physicians to perform IREs. Where the parties are unable to reach agreement on a physician to perform the evaluation, the insurer may request appointment of a physician by the Department. This request shall be made on a form prescribed by the Department. Within 20 days of receipt of an appointment request, the Department will provide the parties with the name and address of the physician appointed to perform the IRE. The insurer is responsible for scheduling the date and time of the evaluation. The Department has established through the statement of policy and these proposed amendments a process whereby the physician performing IREs shall indicate the impairment rating of the employe on an "Impairment Rating Determination Face Sheet" (face sheet). Physicians are to attach the "Report of Medical Evaluation" as utilized by the "AMA Guides to the Evaluation of Permanent Impairment" to the face sheet and provide the completed Face Sheet and report to the insurer, employe, employe's counsel, if known, and the Department within 30 days of the date of the IRE.

These proposed amendments interpret section 306(a.2) of Act 57 as self-executing after notice to the employe. Therefore, after receipt of the face sheet, if appropriate, an insurer may adjust the employe's benefit status by providing written notice to the employe, employe's counsel, if known, and the Department, on a form prescribed by the Department, that: (1) the evaluation has resulted in an impairment rating of less than 50%; (2) 60 days from the date of the notice the employe's benefit status shall be adjusted from total to partial; (3) the adjustment of benefit status does not change the amount of the weekly workers' compensation benefit; (4) the employe may appeal an adjustment of benefit status by filing a Petition for Review with the Department; and (5) an employe may only receive partial disability benefits for a maximum of 500 weeks.

If an IRE is performed within 60 days of the expiration of the employe's receipt of 104 weeks of total disability benefits, the adjustment of benefit status from total to partial shall relate back to the date of the expiration of 104 weeks of total disability benefits. If the IRE is performed more than 60 days after the expiration of the employe's receipt of 104 weeks of total disability benefits,

the adjustment of benefits from total to partial shall be effective as of the date of the evaluation or as determined by the evaluating physician.

Under section 306(a.2)(2) of the act, no reduction shall be made until 60 days notice of modification is given. Therefore, although an adjustment of the benefit status may relate back to the expiration of 104 weeks of total disability benefits, the insurer is required to provide the employe with 60 days notice prior to effectuating the retroactive benefit status adjustment.

At any time during the receipt of the 500 weeks of partial disability benefits, an employe may appeal the adjustment of benefit status to a Workers' Compensation judge by filing a petition for review with the Department. The employe shall produce a physician's determination that the employe's impairment rating is equal to or greater than 50% under the "AMA Guides to the Evaluation of Permanent Impairment." The physician chosen by the employe to perform the impairment rating shall be licensed in this Commonwealth and Board-certified by an American Board of Medical Specialty or its osteopathic equivalent and be active in clinical practice for at least 20 hours per week.

(4) *Subchapter C. Qualifications for Vocational Experts Approved by the Department*

Subchapter C focuses on the amendment to section 306(b)(2) of the act which provides that insurers may require an employe to submit to an interview by an expert approved by the Department and selected by the insurer. These proposed amendments interpret the term "expert" to mean a vocational evaluator who will conduct earning power assessment interviews. To ensure the level of expertise and professionalism required to conduct earning power assessment interviews, the Department has established, through these proposed amendments, minimum qualifications an individual must meet in order to be considered as an expert approved by the Department. These qualifications ensure access to vocational evaluators without increasing costs to insurers and employes seeking earning power assessments.

(5) *Subchapter D. Earning Power Determinations*

Subchapter D effectuates the amendments to section 306(b)(2) and (b)(3) of the act. The Department, through these proposed amendments, interprets section 306(b)(3) of the act to require that notice be provided to the employe and the employe's counsel, if known, regardless of whether the insurer intends to seek a modification or suspension of the employe's benefits. If the insurer intends to seek a modification or suspension of the employe's benefits, the notice must be provided to the employe prior to or contemporaneous with the filing of a petition for modification or suspension.

Section 306(b)(2) of the act provides that if a specific job vacancy exists with the liable employer that the employe is capable of performing, the employer must offer that job to the employe. The Department interprets this section as a threshold requirement prior to seeking a modification or suspension of benefits based on earning power. These proposed amendments provide that this threshold requirement may be satisfied if the employer avers on the petition for modification or suspension and provides evidence at a hearing that: (1) the employe was notified of a job vacancy and failed to respond; (2) a specific job vacancy was offered to the employe, which the employe refused; (3) the employer offered a modified job to the employe, which the employe refused; or (4) no job vacancy exists within the usual employment area.

The Department has determined that the employer's obligation to offer a job that the employe is capable of performing arises when the insurer notifies the employe that the employe is able to return to work and provides the notice as required under section 306(b)(3) of the act. The liable employer's obligation continues for a period of 30 days from the date of the notice or until the insurer files a petition for modification or suspension, whichever is longer.

To provide further clarification of the employer's obligation under section 306(b)(2) of the act, § 123.302 (relating to employer job offer obligation) of these proposed amendments provides that while the obligation to offer a specific job continues for a minimum of 30 days, employers are not required to hold a job open for the employe for 30 days. Job offers are to be made consistent with the employer's usual business practice. Accordingly, if the employer's business practice mandates that a job be held open for 5 days after the making of an offer, the employer is required to utilize this same practice when offering a job to an injured employe. If a specific job vacancy, which the employe is capable of performing, becomes available during the 30-day period, the employer is under an obligation to offer the job to the employe. In cases where more than one job which the employe is capable of performing becomes available, the employer maintains the right to select which job will be offered to the employe. If the employe fails to respond to the offer or refuses the offer, the employer's obligation has been met. Furthermore, the provisions of a collective bargaining agreement which govern the manner in which job offers are made shall control for purposes of offering a specific job vacancy to the employe under section 306(b)(2) of the act. Further, a job may not be considered vacant if the employer is precluded from offering the job to a particular employe because a collective bargaining agreement limits the type of position that the employe may hold.

Where the employer avers that no job vacancy exists, the employe may rebut the employer's averment by demonstrating facts which may include, but are not limited to, the following: (1) the employer is or was actively recruiting for a specific job vacancy that the employe is capable of performing; or (2) the employer has posted or announced the existence of a specific job vacancy, that the employe is capable of performing, which the employer intends to fill. In all situations the employe must meet or exceed the requirements of the position. In addition, the existence of specific jobs as averred by the employe is only relevant during the period in which the employer had a duty to offer a specific job.

(6) *Subchapter E. Collective Bargaining*

Act 57 amended the act to permit any employer and the recognized or certified and exclusive representative of its employes to establish, through collective bargaining, certain binding obligations and procedures for the resolution of claims relating to workers' compensation. Act 57 encourages utilization of this enabling language and the Department's Office of Labor-Management Cooperation is available to provide assistance to interested parties.

It is envisioned that this section will provide flexibility between management and labor organizations to resolve workers' compensation claims in an expeditious manner, while preserving the benefits and protections of the act.

Collective bargaining agreements may provide an alternative dispute resolution (ADR) system which may include, but is not limited to, arbitration, mediation and conciliation for the resolution of claims for work-related injuries.

Standard forms utilized by the Department and filing requirements of the act remain in effect for parties participating in an ADR system under section 450 of the act (77 P. S. § 1000.6). Forms submitted to the Department shall indicate that the parties involved are participating in an ADR system.

All determinations made under an ADR system established under section 450 of the act shall be binding and enforceable. Appeals from determinations rendered under an ADR system are limited to those made under the conditions specified by 42 Pa.C.S. § 7314 (relating to vacating award by court).

Collective bargaining agreements may provide that in the event of the termination or expiration of the agreement, the parties shall be subject to the terms and conditions of the expired agreement until a new collective bargaining agreement becomes effective. In that instance, ADR systems in place at the time the agreement expires shall continue to be the exclusive system for the resolution of the workers' compensation claims.

(7) *Subchapter F. Employe Reporting and Verification Requirements*

Act 57 creates new reporting requirements for employes who file for, or are receiving, workers' compensation benefits. The reporting requirements are intended not only to facilitate the management of claims, but also to reduce fraud within the workers' compensation system. The insurer shall notify the employe, at the time of the work injury or upon commencing payment of compensation, of the duty to report under this section, and shall provide the employe with the necessary forms.

Under section 311.1(a) of the act (77 P. S. § 631.1), employes who file for, or are receiving, compensation shall report information to the insurer which is relevant to determining the entitlement to, or the amount of, compensation. The information includes, but is not limited to, information regarding employment, including voluntary employment, self-employment, wages earned, and the receipt of any benefits referred to in section 204 of the act. The employe is obligated to report this information on form LIBC-750, "Employee Report of Wages (other than Workers' Compensation Benefits Received)" within 30 days of commencing employment or self-employment.

Under section 311.1(d) of the act, insurers may submit form LIBC-760, "Employee Verification of Employment, Self-employment or Change in Physical Condition" to an employe and the employe's counsel, if known, to verify that the employe's status regarding the entitlement to receive compensation has not changed. The form requires that the employe supply all information which is relevant to determining the amount of, or entitlement to, compensation. The employe shall complete and return the verification form to the insurer within 30 days of its receipt. The employe's failure to return the form in the specified time period may result in a suspension of the employe's workers' compensation wage-loss benefits, under section 311.1(g) of the act. It is the insurer's burden to establish that the employe has received the verification form. The insurer's burden is met if it provides evidence that the form was mailed to the employe's last known address, by first-class mail.

The Department has interpreted the provisions of section 311.1(d) of the act to be self-executing upon notification by the insurer. The insurer shall suspend payments of compensation by providing written notice to the employe and the employe's counsel, if known, on Form LIBC-762, "Notice of Suspension for Failure to Return Form LIBC-760 (Employee Verification of Employment, Self-employment or Change in Physical Condition)," that the workers' compensation benefits have been suspended as a result of the employe's failure to return the verification form within the statutory time period. The notice shall further inform the employe that the workers' compensation benefits shall be reinstated within 15 days of the insurer's receipt of the verification form. In addition, the notice shall inform the employe of the right to challenge the suspension of benefits by filing a petition for review with the Department. Employes are not entitled to payments of compensation during the period of noncompliance with this section. Failure to comply with section 311.1(d) of the act may subject the employe to prosecution under Article XI of the act relating to fraud. In addition, failure to reinstate compensation within 15 days of receiving the form may subject the insurer to penalties under section 435 of the act (77 P. S. § 991).

Upon receipt of the completed verification form, the insurer shall reinstate benefits for which the employe is eligible. The insurer shall submit Form LIBC-763, "Notice of Reinstatement of Workers' Compensation Benefit," to the employe, employe's counsel, if known, and the Department, indicating the date of receipt of the verification form and the date of reinstatement of workers' compensation benefits. A failure to do so may result in the imposition of penalties under section 435 of the act.

(8) *Subchapter G. Automatic Request for Supersedeas and Return to Work*

Act 57 amended section 413 of the act by adding subsection (a.1) and (d) and amending subsection (c) (77 P. S. §§ 771(a.1), 774.2 and 774.3). Subsection (a.1) provides for an automatic request for supersedeas when a petition alleging full recovery is filed, accompanied by a physician's affidavit to that effect. The physician's affidavit alleging full recovery must have been completed in connection with an examination which occurred within 21 days of the filing of the petition.

These proposed amendments provide in § 123.601 (relating to disposition of automatic request for special supersedeas) that if a Workers' Compensation judge fails to conduct a special supersedeas hearing within 21 days of assignment of the request or fails to issue a written order within 7 days of the hearing, the supersedeas request shall be deemed denied.

Section 413(c) and (d) of the act (77 P. S. §§ 774.2 and 774.3) allows an insurer to suspend or modify compensation upon the employe's return to work. If the employe is receiving wages greater than or equal to the pre-injury wage, the insurer is entitled to suspend the payment of wage-loss benefits. If the employe has returned to work at wages less than the pre-injury wage, the insurer is entitled to a modification of the wage-loss benefits. Sections 413(c) and (d) of the act are self-executing upon the filing of the required forms and affidavit by the insurer. These subsections require the insurer to notify the employe and the employe's counsel, if known, and the Department, by Forms LIBC-751, "Notification of Suspension or Modification under §§ 413(c) & (d)" and LIBC-752, "Insurer's Affidavit Pursuant to Section 413(c) & (d)," within 7 days of suspending or modifying benefits. In cases where the insurer has previously modified or suspended the employe's benefits under section 413(c) or (d) of the act, to effectuate the subsequent modification or suspension of the workers' compensation benefits, the insurer must file additional forms under this section indicating the change in the employe's wages and the corresponding change in the workers' compensation ben-

efits. These proposed amendments provide in § 123.603 (relating to employe request for special supersedeas hearing) that the insurer's right to modify or suspend the employe's workers' compensation benefits may not continue when the employe has requested a special supersedeas hearing and the Workers' Compensation judge fails to hold a special supersedeas hearing within 21 days or fails to issue a written order within 14 days of the hearing approving the modification or suspension of the employe's benefits.

(9) *Subchapter H. Informal Conferences*

Act 57 amended the act by adding section 402.1 (77 P. S. § 711.1) which provides a mechanism for informal conferences. Act 57 intended that informal conferences would expedite the workers' compensation adjudication process by allowing parties the opportunity to meet informally and discuss issues involved in an ongoing case. An informal conference shall only be held when both parties agree to the conference. Section 402.1(b)(iii) of the act provides that each party may be represented, but the employer may only be represented by an attorney at the informal conference if the employe is also represented by an attorney. The Department, through these proposed amendments, construes this section to permit the representation of a corporation in the informal conference by an agent or representative of the corporation other than an attorney. However, when the case is transferred to a Workers' Compensation judge for an adjudication, the corporation shall be represented by an attorney.

(10) *Subchapter I. Use of Optically Scanned documents*

In conjunction with Act 57, the Bureau has implemented a Statewide Comprehensive Information Management Systems (CIMS) Project which is a five phase plan for installation of the Bureau's state-of-the-art computer system for administration of the act. Subchapter I permits the Bureau's use of optically scanned documents and permits these documents to be admissible as evidence. The purpose of this section is optimize the Bureau's use of optically scanned documents where practical and cost efficient, while preserving the integrity of records.

(11) *Subchapter J. Penalty for Unreasonable and Excessive Delay*

Act 57 amended section 435(d)(3) of the act by increasing the penalty to employers for violations of the act accompanied by unreasonable or excessive delay. This change provides incentive for employers and insurers to comply with the act. This section sets forth the time period for which an employer's delay in complying with the act may be deemed unreasonable or excessive.

Summary of Proposed Rulemaking for Chapter 127

Act 57 amended section 306(f.1) of the act by: (1) extending the time period when an injured employe must treat with an employer-designated health care provider; (2) establishing a procedure when the employe is informed of the necessity of invasive surgery; (3) creating a statute of limitations for the filing of applications for Medical Fee Review; (4) eliminating the reconsideration stage of the UR process; and (5) establishing that in cases where a request for UR is filed for physical therapy or occupational therapy, the review will be performed by a reviewer licensed in this Commonwealth in the same profession and having the same specialty as the provider of the treatment under review, regardless of the specialty of the provider who prescribed the treatment.

Organization

This summary is organized consistent with the order these topics are covered by the Medical Cost Containment regulations. Therefore, the proposed amendments will be addressed in the following order.

Subchapter B. Medical Fees and Fee Review

The Department proposes an amendment to § 127.208(e) (relating to time for payment of medical bills) to delete the language which references both the initial and reconsideration stages of UR. The Department further proposes the amendment of the regulations in this subchapter relating to review of medical fee disputes to provide for the statute of limitations placed on providers by Act 57 for those who wish to file applications for fee review.

Subchapter C. Medical Treatment Review

The Department proposes the amendment of this subchapter to delete any language which references the initial or reconsideration stage of UR. Due to the elimination of the reconsideration stage, the initial request for UR is the only UR available, prior to a de novo hearing before a workers' compensation judge. Therefore, the initial language is extraneous and does not reflect the nature of the UR process as it exists after the passage of Act 57. The Department proposes the deletion of §§ 127.505—127.515. However, the Department maintains the right to collect outstanding amounts owing due to the previous reconsideration of a utilization review determination.

Subchapter D. Employer List of Designated Providers

The Department proposes the amendment of Subchapter D to incorporate Act 57's amendment to the time period for which an employe is required to treat with an employer-designated health care provider and which establishes the procedure the employe is required to follow when a designated provider prescribes invasive surgery for the employe.

Effective Date

These proposed amendments will be effective immediately upon publication.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on June 18, 1997, the Department submitted a copy of these proposed amendments to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the House Labor Relations Committee and the Senate Committee on Labor and Industry (Standing Committees). In addition to submitting the proposed amendments, the Department has provided IRRC and the standing Committees with a copy of a detailed Regulatory Analysis Form prepared by the Department in compliance with Executive Order 1996-1, Regulatory Review and Promulgation. A copy of this material is available to the public upon request.

If the standing Committees have objections to any portion of the proposed amendments, they will notify the Department within 20 days of the close of the public comment period. If IRRC has objections to any portion of the proposed amendments, it will notify the Department within 30 days of the close of the public comment period. The notifications shall specify the regulatory review criteria which have not been met by that portion of the proposed amendments. The Regulatory Review Act specifies detailed procedures for review by the Department,

the General Assembly and the Governor, of objections raised prior to final publication of the final-form regulations.

Public Comment and Contact Person

For further information regarding this proposed rulemaking, interested parties may contact Richard A. Himler, Director, Bureau of Workers' Compensation, P. O. Box 3466, Harrisburg, PA 17105. Interested persons are invited to submit written comments to Richard A. Himler, Director, at the address listed above, within 30 days following publication in the *Pennsylvania Bulletin*. Written comments received by the Department may be made available to the public.

JOHNNY J. BUTLER,
Secretary

Fiscal Note: 12-50. No fiscal impact; (8) recommends adoption. There will be undeterminable costs to the Department of Labor and Industry association with these amendments. These costs will be offset by expected savings to the Commonwealth as a self-insured employer.

Annex A

TITLE 34. LABOR AND INDUSTRY

PART VIII. BUREAU OF WORKERS' COMPENSATION

CHAPTER 123. GENERAL PROVISIONS—PART II

Subch.

Subchapter A. OFFSET OF UNEMPLOYMENT COMPENSATION, SOCIAL SECURITY (OLD AGE), SEVERANCE AND PENSION BENEFITS

Sec.

§ 123.1. Purpose.

This subchapter interprets the provisions of the act which require the offset of workers' compensation benefits by amounts received in unemployment compensation, Social Security (old age), severance and pension benefits, subsequent to the work-related injury.

§ 123.2. Definitions.

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

Act—The Workers' Compensation Act (77 P. S. §§ 1—2626).

Actuarial equivalent—The value of lump-sum pension payout in terms of a monthly benefit had the funds been used to purchase an annuity (either qualified joint and survivor or life annuity) available on the market, considering interest and mortality, at the time of the employe's receipt of the lump-sum benefit.

Defined-benefit plan—A pension plan in which the benefit level is established at the commencement of the plan and actuarial calculations determine the varying contributions necessary to fund the benefit at an employe's retirement.

Defined-contribution plan—A pension plan which provides for an individual account for each participant and for benefits based solely upon the amount of accumulated contributions and earnings in the participant's account. At the time of retirement the accumulated contributions and earnings determine the amount of the participant's benefit either in the form of a lump-sum distribution or annuity.

IRA—Individual retirement account as that term is utilized in 26 U.S.C.A. §§ 219 and 408(a).

Multi-employer pension plan—A plan to which more than one employer is required to contribute and is maintained under one or more collective bargaining agreements between one or more employe organizations and more than one employer.

Net—The amount of unemployment compensation, Social Security (old age), severance or pension benefits received by the employe after required deductions for local, State and Federal taxes and amounts deducted under the Federal Insurance Contributions Act (FICA) (26 U.S.C.A. §§ 3101—3126).

Pension—A plan or fund established or maintained by an employer, an employe organization, or both, which provides retirement income, in the form of retirement or disability benefits to employes or which results in deferral of income by employes extending to termination of employment and beyond.

Severance benefits—A benefit which is taxable to the employe and paid as a result of the employe's separation from employment by the employer liable for the payment of workers' compensation, including benefits in the form of tangible property. The term does not include payments received by the employe based on unused vacation or sick leave or otherwise earned income.

Social Security (old age)—Benefits received by an employe under the Social Security Act (42 U.S.C.A. §§ 301—1397(e)) (relating to Social Security Retirement Income).

§ 123.3. Employe report of benefits subject to offset.

(a) Employes shall report to the insurer amounts received in unemployment compensation, Social Security (old age), severance and pension benefits on Form LIBC-756(A). This includes amounts withdrawn or utilized from pension funds which were rolled over into an IRA or other similarly restricted account while at the same time the employe is receiving workers' compensation benefits.

(b) Form LIBC-756(A) shall be completed and forwarded to the insurer within 30 days of the employe's receipt of any of the benefits specified in subsection (a) or within 30 days of any change in the receipt of the benefits specified in subsection (a), but in any event no less than every 6 months.

§ 123.4. Application of the offset, generally.

(a) After receipt of Form LIBC-756(A), the insurer may offset workers' compensation benefits by amounts received by the employe from any of the sources in § 123.3 (relating to employe report of benefits subject to offset).

The offset of workers' compensation benefits shall only apply with respect to amounts of unemployment compensation, Social Security (old age), severance and pension benefits received subsequent to the work-related injury.

(1) The offset shall apply only to wage-loss benefits (as opposed to medical benefits, specific loss or survivor benefits).

(2) The offset for amounts received in Social Security (old age), severance and pension benefits shall only apply to individuals with claims for injuries suffered on or after June 24, 1996.

(3) The offset for amounts received in unemployment compensation benefits applies to all claims regardless of the date of injury.

(b) At least 15 days prior to taking the offset, the insurer shall notify the employe, on Form LIBC-761, "Notice of Workers' Compensation Benefit Offset," that the workers' compensation benefits will be offset. The notice shall indicate:

(1) The amount of the offset.

(2) The type of offset (that is—unemployment compensation, Social Security (old age), severance or pension).

(3) How the offset was calculated, with supporting documentation, which may include information provided by the employe.

(4) When the offset commences.

(5) The amount of any recoupment, if applicable.

(c) Whenever the insurer's entitlement to the offset changes, the insurer shall notify the employe of the change at least 15 days prior to the adjustment on the form specified in subsection (b).

(d) The insurer shall provide a copy of the form, specified in subsections (b) and (c), to the employe, the employe's counsel, if known, and the Department. It is the insurer's burden to establish that the employe has received a copy of the form specified in subsections (b) and (c). The insurer's burden is met if it provides evidence that the form was mailed to the employe, at the employe's last known address, by first-class mail.

(e) The employe may challenge the offset by filing a petition for review with the Department.

§ 123.5. Offset for benefits already received.

(a) If the insurer receives information that the employe has received benefits from one or more of the sources in § 123.3 (relating to employe report of benefits subject to offset), the insurer shall be entitled to an offset to the workers' compensation benefit.

(b) The net amount received by the employe shall be calculated consistent with §§ 123.6—123.11. The amount received by the employe, prior to notification to the insurer, shall be divided by the weekly workers' compensation rate. The result shall be the number of weeks, and fraction thereof, the insurer is entitled to offset against future payments of workers' compensation benefits.

(c) The insurer shall notify the employe, the employe's counsel, if known, and the Department of the offset as specified in § 123.4(b) (relating to application of the offset, generally).

(d) The employe may challenge the offset by filing a petition for review with the Department.

§ 123.6. Application of offset for unemployment compensation (UC) benefits.

(a) Workers' compensation benefits otherwise payable shall be offset by the amount an employe receives in UC benefits subsequent to the work-related injury. This offset shall apply only to UC benefits which an employe receives and which are attributable to the same time period in which an employe also receives workers' compensation benefits.

(b) The offset may not apply to benefits for which an employe may be eligible, but is not receiving.

(c) When an employe calculates and remits payment for amounts due for Federal, State and local taxes, the insurer may be required to repay the employe for amounts previously offset from workers' compensation benefits, when the offset was calculated on the pretax amount of the UC benefit. To receive repayment for amounts previously offset, the employe shall notify the insurer in writing of the amounts paid in taxes.

(d) The offset to workers' compensation benefits for amounts received in UC benefits is triggered when an employe becomes eligible and begins receiving the UC benefits.

(1) When an employe receives UC benefits which the employe is later required to repay based upon a determination of ineligibility, the insurer may not offset the workers' compensation benefits.

(2) When an employe's workers' compensation benefits have been offset by the amount received in UC benefits and the employe is required to repay UC benefits based upon a determination of ineligibility, the insurer shall repay the employe for the amounts previously offset from the workers' compensation benefits. The employe may request that the insurer remit repayment directly to the Bureau of Unemployment Compensation Benefits and Allowances (BUCBA).

(e) When an employe receives a lump-sum award from BUCBA, the insurer may offset the amount received by the employe against future payments of workers' compensation benefits. The amount received by the employe shall be divided by the weekly workers' compensation rate. The result shall be the number of weeks, and fraction thereof, the insurer is entitled to offset against future payments of workers' compensation benefits.

§ 123.7. Application of offset for Social Security (old age) benefits.

(a) Workers' compensation benefits otherwise payable shall be offset by 50% of the net amount received in Social Security (old age) benefits. The offset shall only apply to amounts which an employe receives subsequent to the work-related injury. The offset may not apply to Social Security (old age) benefits which commenced prior to the work-related injury and which the employe continues to receive subsequent to the work-related injury.

(b) The offset may not apply to benefits to which an employe may be entitled, but is not receiving.

(c) The offset shall be applied on a weekly basis. To calculate the weekly offset, 50% of the net monthly Social Security (old age) benefit received by the employe shall be divided by 4.34.

§ 123.8. Offset for pension benefits, generally.

(a) Workers' compensation benefits otherwise payable shall be offset by the amount an employe receives in pension benefits to the extent funded by the employer directly liable for the payment of workers' compensation.

(b) The pension offset shall apply to amounts received from defined-benefit and defined-contribution plans.

(c) The offset may not apply to pension benefits to which an employe may be entitled, but is not receiving.

(d) In calculating the offset amount for pension benefits, investment income attributable to the employer's contribution to the pension plan shall be included on a pro-rata basis.

§ 123.9. Application of offset for pension benefits.

(a) Offsets of amounts received from pension benefits shall be achieved on a weekly basis. If the employe receives the pension benefit on a monthly basis, the net amount contributed by the employer and received by the employe shall be divided by 4.34. The result is the amount of the weekly offset to the workers' compensation benefit.

(b) When an employe receives a pension benefit in the form of a lump-sum payment, the actuarial equivalent of the lump-sum with respect to the annuity options (qualified joint and survivor annuity or life annuity) available at the time of the employe's receipt shall be used as the basis for calculating the offset to the workers' compensation benefit. The monthly annuity equivalent shall be divided by 4.34. The result shall be the offset to the workers' compensation benefit on a weekly basis.

(c) Pension benefits which are rolled over into an IRA or other similarly restricted account may not offset workers' compensation benefits, so long as the employe does not utilize or otherwise withdraw funds from the account while simultaneously receiving workers' compensation benefits from the liable employer.

(d) If the employe, while receiving workers' compensation benefits from the liable employer, utilizes or otherwise withdraws funds from the IRA or other similarly restricted account, when the IRA or account is funded in whole or in part by the liable employer's contributions, the insurer shall be entitled to an offset to workers' compensation benefits.

(1) If the employe begins receiving a monthly payment from the IRA or other similarly restricted account, the insurer shall receive an offset to the workers' compensation benefit equal to the offset the insurer would be entitled to if the employe were receiving a monthly pension benefit under subsection (a).

(2) If the employe utilizes or otherwise withdraws an amount from the IRA or other similarly restricted account which is greater than the actuarial equivalent of the lump sum with respect to the annuity options (qualified joint and survivor annuity or life annuity) available at the time of the employe's receipt, the insurer may be entitled to an offset against future payments of workers' compensation benefits in an amount equal to the amount of the funds utilized or otherwise withdrawn by the employe.

(e) The employe shall report the subsequent receipt of funds from the IRA or other similarly restricted account to the insurer on Forms LIBC-756A or LIBC-750.

§ 123.10. Multi-employer pension fund offsets.

(a) When the pension benefit is payable from a multi-employer pension plan, only that amount which is contributed by the employer directly liable for the payment of workers' compensation shall be utilized in calculating the offset to workers' compensation benefits.

(b) To calculate the appropriate offset amount, the portion of the annuity purchased by the liable employer's contributions shall be as determined by the pension fund's actuary. The ratio of the portion of the annuity purchased by the liable employer's contributions to the total annuity shall be multiplied by the net amount received by the employe from the pension fund on a weekly basis. The result is the amount of the offset to be applied to the workers' compensation benefit on a weekly basis.

(c) If the employe receives the multi-employer pension benefit on a monthly basis, the net amount received by the employe shall be multiplied by the ratio of the liable employer's contribution to the pension plan on behalf of the employe; and that product shall be divided by 4.34. The result is the amount of the offset to be applied to the workers' compensation benefit on a weekly basis.

(d) If the employe receives the multi-employer pension benefit in a lump sum, the actuarial equivalent of the lump sum with respect to the annuity options (qualified joint and survivor annuity or life annuity) available at the time of the employe's receipt of the benefit shall be used as the basis for calculating the offset to the workers' compensation benefit. The ratio of the employer's contribution to the pension plan shall be multiplied by the monthly annuity value of the pension benefit. The result shall be divided by 4.34 to achieve the offset to the workers' compensation benefit on a weekly basis.

§ 123.11. Application of offset for severance benefits.

(a) Workers' compensation benefits otherwise payable shall be offset by amounts an employe receives in severance benefits subsequent to the work-related injury. The offset may not apply to severance benefits to which an employe may be entitled, but is not receiving.

(b) The net amount of any severance benefits shall offset workers' compensation benefits on a weekly basis, except as provided in subsections (c) and (d).

(c) When the employe receives severance benefits in a lump-sum payment, the net amount received by the employe shall be divided by the weekly workers' compensation rate. The result is the number of weeks, and fraction thereof, the insurer may offset against future payments of workers' compensation benefits.

(d) When an employe receives a severance benefit in the form of tangible property, the market value of the property, as determined for Federal tax purposes, shall be divided by the weekly workers' compensation rate. The result is the number of weeks, and fraction thereof, the insurer may offset against future payments of workers' compensation benefits.

Subchapter B. IMPAIRMENT RATINGS

Sec.
123.101. Purpose.
123.102. Impairment rating evaluation (IRE) requests.
123.103. Physicians.
123.104. Appointment of physician by Department.
123.105. Impairment rating determination.

§ 123.101. Purpose.

This subchapter interprets section 306(a.2) of the act (77 P. S. § 511.2) which provides for a determination of whole body impairment due to the compensable injury after the receipt of 104 weeks of total disability compensation.

§ 123.102. Impairment rating evaluation (IRE) requests.

(a) Commencing 60 days prior to, and continuing up to 60 days after, the expiration of the employe's receipt of

104 weeks of total disability benefits, the insurer may request the employe's attendance at an IRE. If the evaluation is requested and performed during this time period the adjustment of the benefit status shall relate back to the expiration of the employe's receipt of 104 weeks of total disability benefits. When the evaluation is performed more than 60 days after the expiration of the employe's receipt of 104 weeks of total disability benefits, the adjustment of the disability status shall be effective as of the date of the evaluation or as determined by the evaluating physician.

(b) Absent agreement between the insurer and the employe, an IRE may not be performed prior to the expiration of the employe's receipt of 104 weeks of total disability benefits.

(c) The employe's receipt of 104 weeks of total disability benefits shall be calculated on a cumulative basis.

(d) The insurer shall request the employe's attendance at the IRE in writing on a form designated by the Department, and therein specify the date, time and location of the evaluation and the name of the physician chosen to perform the evaluation. The request shall be made to the employe and employe's counsel, if known.

(e) If the parties cannot agree upon the physician to perform the IRE, the Department will appoint a physician consistent with § 123.104 (relating to appointment of physician by Department).

(f) The insurer's failure to request the evaluation within 60 days of the expiration of 104 weeks of total disability may not result in a waiver of the insurer's right to compel the employe's attendance at an IRE. The insurer maintains the right to request and receive an IRE twice in a 12-month period. The request and performance of IREs may not preclude the insurer from compelling the employe's attendance at independent medical examinations or other expert interviews under section 314 of the act (77 P. S. § 651).

(g) The employe's failure to attend the IRE under this section may result in a suspension of the employe's right to benefits consistent with section 314(a) of the act.

§ 123.103. Physicians.

(a) Physicians performing impairment rating evaluations (IREs) shall:

(1) Be licensed in this Commonwealth and certified by an American Board of Medical Specialties-approved board or its osteopathic equivalent.

(2) Be active in clinical practice at least 20 hours per week.

(b) For purposes of this subchapter, the phrase "active in clinical practice" means the act of providing preventive care and the evaluation, treatment and management of medical conditions of patients on an ongoing basis.

(c) Physicians chosen by employes to perform IREs, for purposes of appealing a previous adjustment of benefit status, shall possess the qualifications enumerated in subsections (a) and (b).

§ 123.104. Appointment of physician by Department.

(a) When the parties are not able to reach agreement on the physician to perform the impairment rating evaluation (IRE), the parties may request the Department to appoint the physician.

(b) The parties may request the Department to appoint a physician on a form designated "Request for Appointment of Physician to Perform Impairment Rating Evaluation."

(c) Within 20 days of receipt of the appointment request, the Department will appoint a physician to perform the IRE.

(d) The Department will provide the name and address of the physician appointed to perform the IRE to the employe, the insurer or employer, and the attorneys, if known. The insurer is responsible for scheduling the time and date of the evaluation.

§ 123.105. Impairment rating determination.

(a) When properly requested under § 123.102 (relating to impairment rating evaluation requests), an impairment rating evaluation (IRE) shall be conducted in all cases and an impairment rating determination must result, unless the evaluating physician indicates on the "Impairment Rating Determination Face Sheet" (Face Sheet) that the impairment of the employe is not subject to being rated under the most recent edition of the "AMA Guides to the Evaluation of Permanent Impairment."

(b) To ascertain an accurate percentage of the employe's whole body impairment, in cases when the evaluating physician determines that the compensable injury incorporates more than one pathology, the evaluating physician may refer the employe to one or more physicians specializing in the specific pathologies which constitute the compensable injury. The referring physician remains responsible for determining the whole body impairment rating of the employe.

(c) The physician performing the IRE shall complete a face sheet, which sets forth the impairment rating as determined by the physician. The physician shall attach to the face sheet the "Report of Medical Evaluation" as utilized by the "AMA Guides to the Evaluation of Permanent Impairment." The face sheet and report is to be provided to the employe, employe's counsel, if known, insurer and the Department within 30 days from the date of the impairment evaluation.

(d) If the evaluation results in an impairment rating that is equal to or greater than 50%, the employe shall be presumed totally disabled and shall continue to receive total disability compensation. The presumption of total disability may be rebutted at any time by a demonstration of earning power in accordance with section 306(b)(2) of the act (77 P. S. § 512(b)(2)) or by an IRE which results in an impairment rating of less than 50%.

(e) If the evaluation results in an impairment rating of less than 50%, the employe shall receive benefits partial in character. To adjust the status of the employe's benefits from total to partial, the insurer shall provide notice to the employe, the employe's counsel, if known, and the Department, on a form to be prescribed by the Department, of the following:

(1) The evaluation has resulted in an impairment rating of less than 50%.

(2) Sixty days from the date of the notice the employe's benefits status shall be adjusted from total to partial.

(3) The adjustment of benefit status does not change the amount of the weekly workers' compensation benefit.

(4) An employe may only receive partial disability benefits for a maximum of 500 weeks.

(5) The employe may appeal the adjustment of benefit status to a Workers' Compensation judge by filing a petition for review with the Department.

(f) At any time during the receipt of 500 weeks of partial disability compensation, the employe may appeal the adjustment of benefit status to a Workers' Compensation judge by filing a petition for review.

Subchapter C. QUALIFICATIONS FOR VOCATIONAL EXPERTS APPROVED BY THE DEPARTMENT

Sec.
123.201. Purpose.
123.202. Qualifications.

§ 123.201. Purpose.

This subchapter interprets the provisions of the act which require the Department to approve experts who will conduct earning power assessment interviews under sections 306(b)(2) and 449 of the act (77 P. S. §§ 512(b)(2) and 1000.5). The experts contemplated by this subchapter are vocational evaluators.

§ 123.202. Qualifications.

To be an expert approved by the Department for the purposes of conducting earning power assessment interviews, the individual shall possess a minimum of one of the following:

(1) Both of the following:

(i) Certification by one of the following Nationally recognized professional organizations:

(A) The American Board of Vocational Evaluators.

(B) The National Board of Certified Rehabilitation Counselors.

(C) The National Certification of Disability Management Specialists.

(ii) One year experience in analyzing labor market information and conditions, industrial and occupational trends, with primary duties providing actual vocational rehabilitation services, which include, but are not limited to, the following:

(A) Job seeking skills.

(B) Job development.

(C) Job analysis.

(D) Career exploration.

(E) Placement of individuals with disabilities.

(2) Certification by a Nationally recognized professional organization under the direct supervision of an individual possessing the criteria in paragraph (1).

(3) Possession of a Bachelor's degree or a valid license issued by the Department of State's Bureau of Professional and Occupational Affairs, so long as the individual is under the direct supervision of an individual possessing the criteria in paragraph (1).

(4) At least 5 years experience primarily in the workers' compensation field prior to August 23, 1996, as a vocational evaluator, with experience in analyzing labor market information and conditions, industrial and occupational trends, with primary duties providing actual vocational rehabilitation services, which include, but are not limited to, the following:

(i) Job seeking skills.

(ii) Job development.

(iii) Job analysis.

(iv) Career exploration.

(v) Placement of individuals with disabilities.

Subchapter D. EARNING POWER DETERMINATIONS

Sec.
123.301. Notice of ability to return to work.
123.302. Employer job offer obligation.
123.303. Evidence of earning power.

§ 123.301. Notice of ability to return to work.

(a) After receipt of medical evidence which indicates that an employe is able to return to work in any capacity, the insurer shall provide prompt written notice on Form LIBC-757, "Notice of Ability to Return to Work," to the employe of the following:

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

(2) The employe's obligation to seek available employment and that proof of available employment may jeopardize the employe's right to receive benefits.

(3) The employe's right to consult with an attorney.

(b) This notice shall be provided prior to, or contemporaneous with, the filing of a petition for modification or suspension. The insurer shall provide the notice required by subsection (a), to the employe and the employe's counsel, if known, regardless of whether the insurer intends to file a petition for modification or suspension.

§ 123.302. Employer job offer obligation.

(a) If a specific job vacancy exists, within the usual employment area, with the liable employer, which the employe is capable of performing, the employer shall offer that job to the employe prior to seeking a modification or suspension of benefits based on earning power.

(b) The employer's obligation to offer a specific job vacancy to the employe commences when the insurer provides the notice to the employe required by § 123.301 (relating to notice of ability to return to work) and shall continue for 30 days or until the filing of a petition for modification or suspension, whichever is longer.

(c) When more than one job which the employe is capable of performing becomes available, the employer maintains the right to select which job will be offered to the employe.

(d) The employer's duty under subsections (a)—(c) does not require the employer to hold a job open for a minimum of 30 days. Job offers shall be made consistent with the employer's usual business practice. If the making of job offers is controlled by the provisions of a collective bargaining agreement, the offer shall be made consistent with those provisions.

(e) The employer's duty under subsections (a)—(c) may be satisfied if the employer avers on the petition for modification or suspension and provides evidence that one of the following exists:

(1) The employe was notified of a job vacancy and failed to respond.

(2) A specific job vacancy was offered to the employe, which the employe refused.

(3) The employer offered a modified job to the employe, which the employe refused.

(4) No job vacancy exists within the usual employment area.

(f) Where the employer avers that no job vacancy exists, the employe may rebut the employer's averment by demonstrating facts which may include, but are not limited to, the following:

(1) During the period in which the employer has or had a duty to offer a specific job, the employer is or was actively recruiting for a specific job vacancy that the employe is capable of performing.

(2) During the period in which the employer had a duty to offer a specific job, the employer posted or announced the existence of a specific job vacancy, that the employe is capable of performing, which the employer intends to fill.

(g) A job will not be considered vacant if the employe's ability to fill the position is precluded by any applicable collective bargaining agreement.

§ 123.303. Evidence of earning power.

An insurer may demonstrate an employe's earning power by expert opinion evidence relative to the employe's capacity to perform a job and the existence of a job in the usual employment area of the employe. For injuries suffered on or after June 24, 1996, the employer's job offer obligation to the employe is limited as set forth in § 123.302 (relating to employer job offer obligation).

Subchapter E. COLLECTIVE BARGAINING

Sec.
123.401. Use of alternative dispute resolution (ADR) systems.

§ 123.401. Use of alternative dispute resolution (ADR) systems.

(a) Collective bargaining agreements (CBAs) may provide for an ADR system which may include, but is not limited to, arbitration, mediation and conciliation, for the resolution of claims for work-related injuries.

(b) Standard forms and filing requirements of the act remain in effect for parties participating in an ADR system under section 450 of the act (77 P. S. § 1000.6). Forms submitted to the Department shall indicate that the parties involved are participating in an ADR system under section 450 of the act (77 P. S. § 1000.6).

(c) Once established by a CBA, an ADR system shall be the exclusive system for resolving claims for work-related injuries during the existence of the CBA or longer, if the CBA provides for the continuation of the ADR system. When the ADR system governing a work-related injury is no longer in effect, resolution of claims regarding the work-related injury shall be fully subject to the act, including review by a Workers' Compensation judge.

(d) Determinations rendered under an ADR system shall be binding and enforceable.

(e) Appeals from determinations rendered under an ADR system are limited to those made under the conditions specified by 42 Pa.C.S. § 7314 (relating to Vacating award by court).

Subchapter F. EMPLOYE REPORTING AND VERTIFICATION REQUIREMENTS

Sec.
123.501. Reporting requirement .
123.502. Verification.

§ 123.501. Reporting requirement.

An insurer shall notify the employe of the employe's reporting requirements under sections 204 and 311.1(a) and (d) of the act (77 P. S. §§ 71 and 631.1(a) and (d)). In addition, the insurer shall provide to the employe the forms required to fulfill the employe's reporting and verification requirements.

§ 123.502. Verification.

(a) Insurers may submit Form LIBC-760, "Employee Verification of Employment, Self-employment or Change in Physical Condition," to the employe and employe's counsel, if known, to verify that the status of the employe's entitlement to receive compensation has not changed.

(b) The employe shall complete and return the verification form to the insurer within 30 days of receipt of the form.

(c) If the employe fails to comply with subsection (b), the insurer may suspend payments of wage-loss benefits until the verification form is returned by the employe. It is the insurer's burden to demonstrate that the employe received the verification form. The insurer's burden is met if it provides evidence that the form was mailed to the employe at the employe's last known address, by first-class mail.

(d) To suspend payments of compensation due to the employe's failure to comply with subsection (b), the insurer shall provide written notice to the employe, the employe's counsel, if known, and the Department, on Form LIBC-762, "Notice of Suspension for Failure to Return Form LIBC-760 (Employee Verification of Employment, Self-employment and Change in Physical Condition)" of the following:

(1) The workers' compensation benefits have been suspended because of the employe's failure to return the verification form within the statutorily prescribed time period.

(2) The workers' compensation benefits shall be reinstated by the insurer within 15 days of receipt of the completed verification form.

(3) The employe has the right to challenge the suspension of benefits by filing a petition for review with the Department.

(e) Within 15 days of receipt of the completed verification form, the insurer shall reinstate the workers' compensation benefits for which the employe is eligible. The insurer shall provide written notice to the employe, employe's counsel, if known, and the Department, on Form LIBC-763, "Notice of Reinstatement of Workers' Compensation Benefits," that the employe's workers' compensation benefits have been reinstated due to the return of the completed verification form. The notice shall further indicate the date the verification form was received by the insurer and the date of reinstatement of workers' compensation benefits.

(f) Employes are not entitled to payments of workers' compensation during periods of noncompliance with subsection (b).

Subchapter G. SPECIAL SUPERSEDEAS

Sec.
123.601. Disposition of automatic request for special supersedeas.
123.602. Return to work—modification or suspension.
123.603. Employe request for special supersedeas hearing.

§ 123.601. Disposition of automatic request for special supersedeas.

(a) The filing of a petition alleging full recovery, accompanied by a physician's affidavit to that effect, which was prepared in connection with an examination of the employe no more than 21 days from the filing of the petition, shall act as an automatic request for supersedeas.

(b) A special supersedeas hearing will be held within 21 days of the assignment of the petition filed under this section.

(c) The Workers' Compensation judg shall approve the request for supersedeas if prima facie evidence of a change in the medical status or of any other fact which would serve to modify or terminate the payment of compensation is submitted at the hearing. In making this determination the Workers' Compensation judge shall consider the physician's affidavit alleging full recovery and may consider the following:

(1) The report of the physician.

(2) The testimony of a party or witness.

(3) The records of a physician, hospital or clinic or other similar entity.

(4) The written statements or reports of another person expected to be called by a party at the hearing of the case.

(5) Other evidence relevant to the request for supersedeas.

(d) If the judge to whom the special supersedeas request has been assigned fails to hold a hearing within 21 days of assignment of the request to the judge or fails to issue a written order within 7 days of the hearing of the supersedeas request, the automatic request for supersedeas shall be deemed denied.

(e) The automatic request for supersedeas shall remain denied until the judge issues a written order granting the supersedeas, in whole or in part.

§ 123.602. Return to work—modification or suspension.

(a) If an employe returns to work the insurer may modify or suspend the workers' compensation benefits.

(b) The insurer shall complete and file Form LIBC-751, "Notification of Modification or Suspension Pursuant to §§ 413(C) & (D) and Form LIBC-752, "Insurer's Affidavit Pursuant to Section 413(c) and (d)." Both forms shall be provided to the employe, employe's counsel, if known, and the Department within 7 days of the effective date of the suspension or modification of the workers' compensation benefits.

(c) When the insurer previously modified or suspended the employe's benefits under section 413(c) or (d) of the act (77 P. S. § 774.2 or § 774.3), to effectuate a subsequent modification or suspension of the employe's workers' compensation benefits, the insurer shall file the forms under subsection (b) indicating the change in the employe's wages and corresponding change in the employe's workers' compensation benefits.

§ 123.603. Employe request for special supersedeas hearing.

(a) This section governs the disposition of an employe's request for a special supersedeas hearing made in connection with a challenge to the suspension or modification of workers' compensation benefits under section 413(c) and (d) of the act (77 P. S. §§ 774.2 and 774.3).

(b) A special supersedeas hearing will be held within 21 days of the employe's filing of the notice of challenge.

(c) The Workers' Compensation judge to whom the notice of challenge has been assigned will issue a written order on the challenge within 14 days of the hearing.

(d) If the judge fails to hold a hearing within 21 days or fails to issue a written order approving the suspension or modification of benefits within 14 days of the hearing, the insurer shall reinstate the employe's workers' compensation benefits at the weekly rate the employe received prior to the insurer's suspension or modification of benefits under section 413(c) or (d) of the act.

Subchapter H. INFORMAL CONFERENCE

Sec.
123.701. Representation of corporation at informal conferences.

§ 123.701. Representation of corporation at informal conference.

A corporation may be represented by an agent or other representative of the corporation, other than an attorney, at an informal conference conducted under section 402.1 of the act (77 P. S. § 711.1). When the case is transferred from an informal conference to a Workers' Compensation judge for an adjudication, a corporation shall be represented by an attorney.

Subchapter I. USE OF OPTICALLY SCANNED DOCUMENTS

Sec.
123.801. Use of optically scanned documents.

123.801. Use of optically scanned documents.

(a) The Bureau may optically scan original documents, or make other images or paper copies which accurately reproduce the originals, and may dispose of the originals so copied.

(b) A copy made under this section, and certified by the custodian of records for the Bureau, shall be admissible in evidence in a proceeding with the same effect as though it were an original.

Subchapter J. UNREASONABLE OR EXCESSIVE DELAY

Sec.
123.901. Penalty for unreasonable or excessive delay.

123.901. Penalty for unreasonable or excessive delay.

An employer which violates a provision of the act or regulations accompanied by an unreasonable or excessive delay may be assessed a penalty of up to 50% of the sum of compensation awarded. A delay of 10 or more days shall be presumed to be an unreasonable or excessive delay.

CHAPTER 127. WORKERS' COMPENSATION MEDICAL COST CONTAINMENT

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

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(b) Payments for spinal manipulation procedures by chiropractors shall be based on the Medicare fee schedule for HCPCS **[code A2000] codes 98940-98943,** multiplied by 113%.

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BILLING TRANSACTIONS

§ 127.208. Time for payment of medical bills.

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(e) The 30-day period in which payment shall be made to the provider may be tolled only if review of the reasonableness or necessity of the treatment is requested during the 30-day period under the UR provisions of Subchapter C (relating to medical treatment review). The insurer's right to suspend payment shall continue throughout **[both the initial review and the recon-**

sideration review of] 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 **[at reconsideration]** 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, **[at reconsideration,]** 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 **[at reconsideration]** 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)).

REVIEW OF MEDICAL FEE DISPUTES

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

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

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

Subchapter C. MEDICAL TREATMENT REVIEW

§ 127.401. Purpose-review of medical treatment.

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(c) UR may be requested by **[by multiple parties, depending on whether it is an initial request or a reconsideration request] or on behalf of the employer, insurer or employe.**

[(1) The initial request for UR may be made by, or on behalf of, the employer, insurer or employe.

(2) The request for reconsideration may be made by, or on behalf of the employer, insurer, employe or health care provider.]

(d) A party, **including a health care provider**, aggrieved by the UR **[reconsideration]** determination, may file a petition for review of UR, to be heard and decided by a Workers' Compensation judge.

§ 127.404. Prospective, concurrent and retrospective review.

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

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

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

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

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

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§ 127.405. UR of medical treatment in medical only cases.

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(b) If the insurer files **[an initial] a** request for UR in a medical only case, then the insurer shall be responsible for paying for the costs of the **[initial]** UR.

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

UR—**[INITIAL]** REQUEST

§ 127.451. **[Initial requests] Requests** for UR—who may file.

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

§ 127.452. [Initial requests] Requests for UR—filing and service.

(a) A party seeking UR of treatment rendered under the act shall file the original and 8 copies of a form prescribed by the Bureau as **[an initial] a** request for UR. All information required by the form shall be pro-

vided. If available, the filing party shall attach authorizations to release medical records of the providers listed on the request.

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

(c) **[Initial requests] Requests** for UR shall be sent to the Bureau at the address listed on the form.

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

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

§ 127.453. **[Initial requests] Requests** for UR—assignment by the Bureau.

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§ 127.454. [Initial requests] Requests for UR—reassignment.

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

§ 127.455 **[Initial requests] Requests** for UR—conflicts of interest.

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§ 127.456. **[Initial requests] Requests** for UR—withdrawal.

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

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§ 127.457. Time for requesting medical records.

A URO shall request records from the treating provider listed on the **[initial]** request for UR within 5 days from receipt of the Bureau's notice of assignment.

§ 127.465. **[Initial requests] Requests** for UR—deadline for URO determination.

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§ 127.466. Assignment of UR request to reviewer by URO.

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

[(b) Review of physical therapy, occupational therapy, anesthesia incident to surgical procedures, diagnostic tests, prescriptions and durable medical equipment shall be performed by a reviewer licensed by the Commonwealth in the same profession and having the same specialty as the provider who made the referral, ordered or prescribed the treatment or service.]

§ 127.477. Payment for **[initial]** requests for UR.

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

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

If the **[initial]** 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) **[unless the insurer timely files a request for reconsideration of the initial UR determination under § 127.502 (relating to reconsideration—time for filing)].**

(*Editor's Note*: The Department is proposing to delete §§ 127.501—127.515 (relating to UR—reconsideration) as they currently appear in the *Pennsylvania Code* at pps. 127-54—127-58 (serial pps. (203498)—(203502)).

UR—PETITION FOR REVIEW

§ 127.551. Petition for review by Bureau of UR determination.

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

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

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

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

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

§ 127.555. Petition for review by Bureau—transmission of URO records to Workers' Compensation judge.

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

(b) **[The URO may not forward the report of the reviewer to the Workers' Compensation judge.] When a petition for review has been filed, the Bureau will forward the URO report to the Workers' Compensation judge assigned to the case.**

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§ 127.556. Petition for review by Bureau—de novo hearing.

The hearing before the Workers' Compensation judge shall be a de novo proceeding. **The URO report shall be part of the record before the Workers' Compensation judge and the Workers' Compensation judge shall consider the report as evidence; however, [The] the** Workers' Compensation judge will not be bound **[by prior determinations made during the UR process] by the URO report.**

Subchapter D. EMPLOYER LIST OF DESIGNATED PROVIDERS

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

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(b) If an employer has established a list of providers which meets the requirements of the act and this subchapter, an employe with a work-related injury or illness shall seek treatment with one of the designated providers from the list. The employe shall continue to treat with the same provider or another designated provider for **[30] 90** days from the date of the first visit for the treatment of the work injury or illness.

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(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 **[30] 90**-day period.

* * * * *

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

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

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(e) The employer may change the designated providers on a list. However, changes to the list may not affect the options available to an employe who has already commenced the **[30] 90**-day treatment period.

§ 127.755. Required notice of employe rights and duties.

* * * * *

(b) The contents of the written notice shall, at a minimum, contain the following information **[that the employe has]**:

(1) That 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 **[30] 90** days from the date of the first visit to a designated provider.

(2) That 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 **[30] 90**-day period.

(3) That the employe has the right, during this **[30] 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.

* * * * *

(5) That 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 **[30] 90**-day period.

(6) That the employe has the right to seek treatment or medical consultation from a nondesignated provider during the **[30] 90**-day period, but that these services shall be at the employe's expense for the applicable **[30] 90** days.

(7) That the employe has the right to seek treatment from any health care provider after the **[30] 90**-day period has ended, and that treatment shall be paid for by the employer, if it is reasonable and necessary.

* * * * *

(9) That the employe has the right to seek an additional opinion from any health care provider of the employe's choice when a designated provider prescribes invasive surgery for the employe. 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 a period of 90 days from the date of the first visit to the provider of the additional opinion.

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