RULES AND REGULATIONS

Title 34—LABOR AND INDUSTRY

DEPARTMENT OF LABOR AND INDUSTRY
[34 PA. CODE CHS. 122, 123, 127 AND 131]
General Provisions of Act 57 of 1996

The Department of Labor and Industry (Department), Bureau of Workers' Compensation (Bureau), by this order, adopts the following amendments to clarify and provide detailed guidance for the uniform application 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 is known as the General Provisions—Part II regulations. In addition, as Act 57 abrogated the reconsideration stage of the utilization review (UR) process, the Department, by this order, deletes and amends certain portions of Chapter 127 (relating to workers' compensation medical cost containment). Specifically, the Department deletes §§ 127.501—127.515 (relating to UR—reconsideration). The Department also deletes language throughout Chapter 127 which references both the initial and reconsideration stages of UR. Additionally, the Department amends § 127.105 (relating to outpatient providers subject to the 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 The procedural code A2000 under the Medicare Fee Schedule has been repealed and replaced effective January 1, 1997; therefore, reimbursement of chiropractors is to be governed by the new procedure codes.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 amends the following sections: § 127.252 (relating to application for fee review—filing and service) to incorporate the statute of limitations imposed on providers wishing to file applications for Medical Fee Review under Act 57; § 127.452 (relating to request for UR—filing and service) to clarify the identity of the provider under review when a UR request is filed; § 127.751 (relating to employer's option to establish a list of designated health care providers); § 127.752 (relating to contents of list of designated health care providers); and § 127.755 (relating to required notice of employe rights and duties). The amendments to §§ 127.751, 127.752 and 127.755, 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 and the employe chooses to follow an alternative course of treatment. Further, as Act 57 created new provisions regarding the automatic request for supersedeas and the return-to-work suspension/modification, the Department also adds the supersedeas provisions of Chapter 131, Subchapter C (relating to formal proceedings).

Statutory Authority

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

Background

On June 24, 1996, Governor Tom Ridge signed into law Act 57, which substantially amended the act. The amendments are intended to combat the rising costs of workers' compensation in this Commonwealth while protecting the right 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 to conduct earning power assessment interviews. Further, Act 57 provides for an impairment rating evaluation after an employe's receipt of 104 weeks of total disability compensation, unless otherwise agreed to by the parties. If the impairment rating is less than 50% under the "AMA Guides to the Evaluation of Permanent Impairment," the employe's benefit status shifts from total to partial disability with benefits capped at 500 weeks.

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 (77 P. S. §§ 511 and 512). 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 may enter into Compromise and Release Agreements which

may extinguish the employer's liability for a work-related injury. Act 57 also permits an employer and the recognized or certified exclusive representatives of its employes to collectively bargain 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 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 (77 P. S. § 511.2(f.2)) 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).

Upon the passage of Act 57, the Department commenced a major effort to promulgate comprehensive regulations which would implement Act 57. In this effort, the Department has drawn upon the expertise of both the public officials responsible for the act's administration and the private parties affected by the system. Consequently, the Department has published several documents regarding the promulgation of regulations for Act 57. As early as August of 1996, the Department published a notice at 26 Pa. B. 3979 (August 17, 1996), to which the Department received various written and verbal comments regarding the interpretation of various provisions of Act 57. Additionally, consistent with the Governor's policy in Executive Order 1996-1, the Department has sought out and consulted with stakeholders affected by the passage and implementation of Act 57. Any group which expressed interest in meeting with the Department's Act 57 regulatory committee was afforded the opportunity to do so. In addition to the stakeholders, the Department convened and 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.

After consideration of the comments made by the stakeholder groups, the Department published a statement of policy at 27 Pa. B. 1731 (April 5, 1997) 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 right 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 were given thorough consideration by the Department in drafting the proposed amendments.

At 27 Pa. B. 3141 (June 28, 1997), the Department published the notice of proposed rulemaking, again inviting all interested parties to provide written comments to the Department regarding the Department's interpretation of Act 57. As a result, the Department received comments from the following groups and individuals: David H. Wilderman, Pennsylvania AFL-CIO; Gerard W. Langan, O'Malley & Langan, P.C.; John Cerilli, Buchanan Ingersoll, P.C.; Thomas C. Baumann, Abes Baumann, P.C.; Christina T. Novajosky, O'Malley & Langan, P.C.; Timothy Conboy, Caroselli Spagnolli & Beachler, LLC; Stephen J. Bosacco, M.D., Pennsylvania Orthopaedic Society; Thomas H. Malin, M.D., Chairman, Workers' Compensation Committee of the Pennsylvania Orthopaedic Society; H. Elton Blenden; Lorrie McKinley, Community Legal Services, Inc.; Mark A. Clukey, D.C., Clukey Chiropractic & Rehab.; Steven A. Bennett, American Insurance Association Law Department; John G. DiLeonardo and J. Kent Culley, Tucker Arensberg, P.C.; Victor F. Greco, M.D., President, Pennsylvania Medical Society; Lois S. Hagarty, Pepper Hamilton & Scheetz, LLP; Martha J. Hampton, Galfund Berger Lurie Brigham Jacobs Swan Jurewicz Jensen, Ltd. - as Chair of the Workers' Compensation Section Regulations Committee of the Pennsylvania Bar Association; Roy M. Love, D.C., President of the Pennsylvania Chiropractic Association; Vince Phillips, Vice President for Government Affairs for the Independent Insurance Agents of Pennsylvania; Jay Elliot Shor, Lawrence Levin and Joseph DeRita, Shor, Levin & DeRita, P.C.; Charles S. Katz, Jr., Swartz, Campbell & Detweiler; Fred H. Hait, McGraw, Hait & Deitchman; Mary Anne O'Malley, O'Malley & Langan, P.C.; Samuel R. Marshall, The Insurance Federation of Pennsylvania Inc.; Stuart W. Benson, III, Pietragallo Bosick & Gordon; Anthony J. Bilotti, Duane Morris & Heckscher LLP; Stephen J. Harlen, Swartz, Campbell & Detweiler; and Thomas E. Lucas, Jr., O'Malley & Langan, P.C. The Department also received written comments from the Independent Regulatory Review Commission (IRRC), by means of a letter dated August 27, 1997.

This notice of final rulemaking supplants and further clarifies and expands upon the previous interpretation of Act 57 provided in the notice of proposed rulemaking. In response to comments received, some changes have been made to the previously published interpretation.

Purpose

The purpose of these amendments is to implement Act 57. The amendments in sections 204; 306(a.2), (b)(2) and (3), (f.1)(1)(i) and (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, unless otherwise agreed to, in order to determine the percentage of whole body impairment; the addition of new employe reporting requirements; 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 interpretation and guid-

ance, so that all parties have a clear understanding of their rights and obligations under the Act 57 amendments. These amendments provide the guidance needed to ensure consistent application and compliance with Act 57.

Affected Persons

Those affected by these amendments are all 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 final rulemaking. Although Act 57 required the creation of new Departmental forms for public use, significant costs are not expected. Furthermore, any costs to the regulated community associated with the implementation of these 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.

Response to Comments

The following addresses the common areas of concerns found in the comments received from the public and IRRC.

1. *Offset of Benefits*

Section 123.2 (relating to definitions) of the proposed rulemaking contains the definition of a "multi-employer pension plan." Commentators question whether the definition excludes multiple-employer plans created by trade and employe associations. The definition of "multi-employer pension plan" does exclude these other plans, because typically the funds paid into plans created by trade and employe associations for any individual employe are paid by a single employer. In contrast to these plans, the multi-employer pension plans governed by § 123.10 (relating to multi-employer pension fund offsets) involve employes whose pensions are funded by contributions from more than one employer. The term "multi-employer pension plan" is intended to have the same meaning as found within the Employee Retirement Income Security Act of 1974 (ERISA). Any question regarding the usage of the term and its applicability to a particular plan is governed by the ERISA definition.

Section 123.4(a) (relating to application of the offset, generally) of the proposed rulemaking provided that 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. IRRC, as well as other commentators, believe that the provision should specify that the offset is applicable "subsequent to date of disability"—their concern apparently being that, absent the specification of "disability," the offset may be viewed as accumulating during a period in which the employe is not receiving an indemnity benefit. However, the Department has determined that no change to the language is required for this section. As a general matter, the date of injury is the date which fixes the rights and duties of the parties under the act. Further, the language, as proposed, is consistent with the language in section 204(c) of the act which requires that the employe report the receipt of unemployment compensation, Social Security (old age), severance and pension benefits "which post-date the compensable injury under the act."

Section 123.4(b) of the proposed rulemaking provided that at least 15 days prior to taking the offset, the insurer shall notify the employe that the workers' compensation benefit will be offset. The rationale for requiring notice in this section is to ensure that employes have sufficient time in which to financially plan for any offset. Because the bulk of compensation benefits are paid biweekly, it was determined that the 15-day period provided adequate notice, allowing insurers to include the notice with a scheduled biweekly check. At the suggestion of IRRC and other commentators, the Department has determined that the notice requirement will be changed from 15 to 20 days in order to remain consistent with other notice and filing provisions of the act.

Section 123.4(d) of the proposed rulemaking required that the insurer provide a copy of Form LIBC-761, "Notice of Workers' Compensation Benefit Offset," to the employe, employe's counsel, if known, and the Department. This section further provides that 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." IRRC and other commentators argue that the Department's use of the above-quoted language creates an irrebuttable presumption of the claimant's receipt of the form. The Department has, in the interest of clarity, revised the language of this section to reflect the statutorily prescribed procedures for serving notices and forms under section 406 of the act.

Sections 123.4(e) and 123.5(d) (relating to offset for benefits already received) of the proposed rulemaking provided that an employe may challenge an offset to the workers' compensation benefit by filing a Petition for Review with the Department. IRRC, as well as other commentators, question the lengthiness of this procedure. IRRC specifically suggested that the Department adopt an expedited hearing procedure, similar to that found in section 413(c) and (d) of Act 57, which provides the employe with the opportunity to challenge the return to work suspension/modification, by means of a "check-off box" on the notification form. Although the Department does not adopt IRRC's proposal, the Department does agree that the challenge of the offset should be afforded special consideration. Therefore, the Department has amended LIBC-378, the "Petition to" form, to include a Petition to review offset. While the regulation has not included any expedited procedures, the Department intends to implement internal operating procedures which will expedite the processing of these challenges.

Section 123.6(c) (relating to application of offset for Unemployment Compensation (UC) benefits) of the proposed rulemaking provided that an insurer "may" be required to repay the employe for amounts previously offset from workers' compensation benefits when an employe calculates and remits payments for amounts due in Federal, State and local taxes for the receipt of unemployment compensation benefits. IRRC, as well as other commentators, opined that the use of the permissive term "may" indicates that the insurer would have the option, as opposed to the duty, to reimburse the employe. In the interest of clarity, the Department has changed the term "may" to "shall." Further, IRRC and others suggested that the Department explain the manner by which an employe should seek reimbursement from the insurer. Because parties routinely handle reimbursements to employes without the need for regulation, that is, for travel-related and medical expenses, the Department has determined that there is no need to regulate this issue.

Some commentators suggested that the Department erred in providing an offset based upon the "net" benefit in § 123.6 of the proposed rulemaking. These commentators suggested that the tax treatment of benefits which may be calculated toward an offset of workers' compensation benefits is irrelevant and should not be the subject of regulation. This would result, however, in granting the employer an entitlement to the offset regardless of whether the employe must later pay taxes on the sum. Although the Department disagrees with this analysis, the Department does concur in the suggestion of IRRC and others that the provision in § 123.6(c) for reimbursement where the employe has paid Federal, State and local taxes on amounts which had previously been used to calculate an offset, should be applicable to all the offset provisions. Accordingly, the Department has amended proposed § 123.4 to include subsection (f), which allows reimbursement of sums paid in taxes for unemployment compensation, Social Security (old age), severance or pension benefits if the offset was calculated on the pretax amount. In the interest of consistency, the Department has vacated the language of § 123.6(c) which references only unemployment compensation.

Sections 123.5(b), 123.6(e) and 123.11(c) (relating to application of offset for severance benefits) of the proposed rulemaking contain formulas for determining offset amounts on future payments of workers' compensation when an employe receives a lump-sum award in unemployment compensation, Social Security (old age) and severance benefits. IRRC, the Pennsylvania Trial Lawyers' Association and the Workers' Compensation Section Regulations Committee of the Pennsylvania Bar Association have challenged the formulas contained in the proposed regulations. These commentators assume that, if a Social Security (old age), severance or unemployment compensation benefit is received on a weekly basis and the amount of the weekly offset exceeds the amount of the weekly indemnity benefit, the difference is not subject to the offset. They deduce, therefore, that if the unemployment compensation, Social Security (old age), severance and pension offset results in a lump-sum payment, the proposed regulation, which provided that the offset amount be divided by the weekly compensation rate, permited insurers to receive a greater offset than would have occurred if the same benefit were received on a weekly basis. This interpretation of the offset provisions of Act 57 is without support in the language of the act. The Department, therefore, consistent with Act 57, interprets section 204(a) of the act to mean that any offset calculated on a weekly basis in excess of the weekly workers' compensation rate shall accumulate as a credit toward the future payment of workers' compensation benefits. Therefore, the calculation for all offsets, whether achieved on a weekly basis or in a lump sum, will yield an offset equal to the amount which is eligible to be calculated as an offset.

Finally, there appears to be some confusion over certain terms utilized in §§ 123.3—123.11 which were not specifically defined. The Department has determined that no definitions are necessary, as 1 Pa.C.S. § 1903 (relating to words and phrases) provides that nontechnical words shall be construed according to their common usage.

2. *Impairment Ratings*

Section 123.102(b) (relating to IRE requests) of the proposed rulemaking allowed an impairment rating evaluation (IRE) to be performed prior to the expiration of 104 weeks of total disability when agreed to by the parties. IRRC, as well as several other commentators, expressed the belief that no statutory authority exists for this position. However, the Department, in drafting this regulation, finds support in the express language of section 306(a.2)(1) of the act, which provides "when an employe has received total disability compensation pursuant to clause (a) for a period of one hundred four weeks, unless otherwise agreed to, the employe shall be required to submit to a medical examination which shall be requested by the insurer within sixty days upon the expiration of the one hundred four weeks to determine the degree of impairment due to the compensable injury, if any." (emphasis added) The text of the statute does not contain any restrictions with regard to whether an employe may have the IRE performed prior to the expiration of the 104 weeks, if the parties so agree. Accordingly, the Department has made no change to this section.

IRRC, as well as several other commentators, expressed concern regarding § 123.102(a) of the proposed regulations which permits an insurer to request an impairment rating 60 days prior to the expiration of the employe's receipt of 104 weeks of total disability benefits. The confusion regarding this provision has led the Department to amend the final regulation to reflect that the request for the performance of the IRE may not occur prior to the expiration of the employe's receipt of 104 weeks of total disability benefits, unless otherwise agreed to by the parties.

Section 123.102(h) of the proposed rulemaking provided that an 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 of the act (77 P. S. § 651). IRRC expressed the opinion that this section allows an insurer to unilaterally suspend benefits if the employe fails to attend the IRE. IRRC further suggested that the regulation should be clarified to point out that the benefits may only be suspended in "accordance with the procedures" of section 314 of the act. It is the Department's position that the language as written does, in fact, require the insurer to act in accordance with the provisions of section 314 of the act. However, the Department has determined that the addition of the term "provisions" would add clarity to the language of the section.

Section 123.104(a) (relating to initial IRE; designation of physician by Department) of the proposed rulemaking provides that when parties are unable to reach agreement on a physician to perform an impairment rating evaluation, the parties may request that the Department appoint such a physician. IRRC, as well as other commentators, asked that the Department clarify this provision so that either party may request that the Department designate a physician. The Department, however, declines to embrace this position, instead stating in § 123.104 that only the insurer may request that the Department designate the IRE physician and that the Department's duty to designate an IRE physician pertains only to the initial IRE. Additionally, the Department has revised § 123.104 to clarify that the parties are not required to attempt to reach agreement on who should be the evaluating physician prior to requesting designation by the Department.

Section 123.105(a) (relating to impairment rating determination) of the proposed rulemaking provided that the IRE physician, chosen by the parties or designated by the Department, must render an impairment rating determination after conducting an IRE, unless the evaluating physician indicates on the "Impairment Rating Determination 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." IRRC, as well as others, expressed concern that the proposed regulation did not specify the outcome if the physician does not assign an impairment rating percentage. IRRC specifically suggested that the Department regulate the outcome in such cases.

The Department has determined, however, that no regulation is required because the language of Act 57 expressly controls the outcome if an IRE physician does not assign a percentage rating. Section 306(a.2) of the act describes the outcome if an IRE determination results either in an impairment rating equal to or greater than 50%, or in an impairment rating less than 50%. It is, therefore, axiomatic that if no rating is assigned, the outcomes described in section 306(a.2) of the act are inapplicable.

3. *Qualification of Vocational Experts*

Several commentators, as well as IRRC, noted that the organizations listed for certification of vocational evaluators in the proposed rulemaking are incorrectly named. Accordingly, the Department has amended the regulations to properly identify the certification organizations for vocational evaluators. Commentators also expressed concerns that the qualifications are unnecessarily broad and inadequate to insure the proper qualifications for vocational evaluators. However, the Department maintains that the regulation, as proposed, will promote professionalism within the vocational evaluation field, while at the same time ensuring affordability and accessibility of vocational evaluators to employes and employers alike. As in any other instance of adjudication, all credibility determinations remain the province of the workers' compensation judge.

IRRC noted that the phrase "direct supervision," as used in § 123.202 (relating to qualifications), is confusing and suggests that, in the interest of clarity, the Department define the phrase. However, the Department has determined that this term may be interpreted according to its common usage and, therefore, further definition of the phrase is not needed.

4. *Verification Form and Reporting Requirement*

Section 123.501 (relating to reporting requirement) of the proposed rulemaking provided that the insurer provide the employe with the forms required to fulfill the employe's reporting and verification requirements. IRRC, as well as others, expressed their belief that proposed use of the term "shall" exceeded the statutory authority of section 311.1(d) of the act (77 P. S. § 631.1(d)), which states that the insurer "may" submit a verification form to the employe. However, the commentators' reading of the regulation does not incorporate the employe's duty to return the form sent by the insurer and the serious consequences for the employe's failure to do so. The regulation, as proposed, preserved the insurer's option to send the verification form to the employe while ensuring that, if the insurer intends to exercise the right to suspend an employe's workers' compensation benefits for failure to return the form, the insurer must first have provided the form to the claimant.

Section 123.502 (relating to verification) of the proposed rulemaking contained provisions for verification of an employe's employment status and change in physical condition. IRRC, as well as other commentators, raised several concerns with this section. The initial concern is with regard to the manner in which an insurer's burden of proof with respect to sending the form to the claimant is to be met. As with § 123.4(d), the Department has amended this section to provide that the verification form, if mailed, may be served on the employe in accordance with section 406 of the act.

Section 123.502(d)(1) of the proposed rulemaking provided that Form LIBC-762, "Notice of Suspension for Failure to Return LIBC-760" indicate that the employe failed to return the form within the statutorily prescribed time period. IRRC recommended that, in the interest of clarity and providing notice to the employe, the statutorily prescribed time period be included in the "Notice of Suspension for Failure to Return LIBC-760." Accordingly, § 123.502(d)(1) and the corresponding form have been amended to include language that the employe must return Form LIBC-760, "Employee Verification of Employment, Self-Employment, or Change in Physical Condition," within the "30-day statutorily prescribed time period."

Section 123.502(d)(2) of the proposed rulemaking, which stated that the workers' compensation benefit shall be reinstated by the insurer within 15 days of receipt of the completed verification form, raised some concern with IRRC, as well as other commentators. Specifically, the commentators assumed that the language extended the insurer's suspension for a period of 15 days beyond the date the form was returned. The Department's inclusion of the 15-day period in which to reinstate benefits was for the sole purpose of providing a reasonable period in which an employer may process the reinstatement of benefits, beginning from the date the employe returned the form. However, the Department has, in the interest of clarity, deleted the 15-day requirement of this section.

IRRC and other commentators express concern with regard to the provision of § 123.502(f) which provided that employes forfeit the right to payment of indemnity benefits during periods of noncompliance with the verification reporting requirements. IRRC and others, contend that the forfeiture of benefits in this context is contrary to Act 57 and its Legislative intent. In particular, IRRC suggested that the Legislature's use of the term "suspension" should be interpreted as a "temporary postponement of benefits." It should be noted that a "temporary postponement of benefits" is a concept foreign to the Pennsylvania workers' compensation system; in contrast, the term "suspension" has an established meaning within the practice of workers' compensation case law and within other sections of the act, that is, sections 314 and 413(c) and (d) of the act, which confirm that the term "suspension" as used in this section has no other interpretation except that the employe has permanently forfeited the right to compensation. Accordingly, no change has been made to this section.

5. *Disposition of Automatic Request for Supersedeas*

Section 123.601(c), as proposed, stated that a workers' compensation judge 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. This provision is found in section 413(a.1) of Act 57. As pointed out by IRRC and several commentators, section 413(a.1) of Act 57 further provides "unless the employe establishes, by a preponderance of the evidence a likelihood of prevailing on the merits of his defense." The commentators have indicated and the Department concurs, that the language of the regulation should reflect the language of Act 57 which establishes the employe's opportunity to rebut the prima

facie evidence presented by the insurer. Accordingly, the Department incorporates this additional language in the final-form rulemaking.

It should be noted that Subchapter G of the proposed rulemaking in §§ 123.601—123.603 provided for the procedures surrounding the disposition of the automatic request for supersedeas under section 413(a.1) of the act (77 P. S. § 774.2) and the disposition of the employe's request for special supersedeas hearing in connection with the return to work suspension/modification of section 413(c) and (d) of the act (77 P. S. §§ 774.2 and 774.3). After further review of these sections and of comments received, the Department has determined that the procedures for the disposition of these supersedeas requests are more appropriately addressed under the Special Rules of Administrative Practice and Procedure Before Referees contained in Chapter 131. Therefore, Subchapter G of the rulemaking is now codified under Chapter 131 in §§ 131.49—131.51. As a result, the remaining sections of the rulemaking, that is, informal conferences and optical scanning, have been renumbered under Subchapters G and H respectively.

6. *Informal Conferences*

Section 123.701 of the proposed rulemaking stated that a corporation may be represented by an agent or other representative of the corporation other than an attorney, at an informal conference. Commentators have asserted that the language provided for the unauthorized practice of law. IRRC recommended that the language be amended to mirror the language of Act 57. In the alternative, IRRC recommends that the section be deleted in its entirety. The Department has determined that § 123.701, as written, clarifies that the informal conference is not an adversarial proceeding and that participation is optional. As such, the representation of a corporation by an attorney at the informal conference is neither required by law nor is representation the unauthorized practice of law. Furthermore, the codification of existing law in this regard promotes the use of this section. The Department maintains that the language, as proposed, fulfills the intent of this section; however, in the interest of clarity the Department has amended this section to more precisely reflect the provisions of section 402.1 of Act 57.

7. *Unreasonable or Excessive Delay*

Section 123.901 of the proposed rulemaking stated that a delay of 10 or more days shall be presumed to be an unreasonable or excessive delay. IRRC and others expressed concern that the creation of such a "presumption" would require judges to find that an unreasonable or excessive delay had occurred after the expiration of 10 days. Although the Department provided the 10-day period as a means to lend uniformity to determinations of unreasonable or excessive delay, by establishing an expectation for the time in which an insurer may accomplish the administrative steps to fulfill duties under the act, the commentators expressed unanimous opposition to this provision. The Department has decided that § 123.901 should be deleted. As in the past, a finding of unreasonable and excessive delay is within the discretion of the workers' compensation judge.

Reporting, Recordkeeping and Paperwork Requirements

A number of forms were necessary to implement and interpret Act 57 and to implement the provisions of this final-form rulemaking. Some of these forms were created under the explicit instructions of Act 57, while others were designed to effectively implement Act 57, from a practical, administrative standpoint. The following is a list of new forms and a short explanation of their origin:

1. Form LIBC-756, "Employee's Report of Benefits," and Form LIBC-750, "Employee Report of Wages (Other Than Workers' Compensation Benefits Received)," were created under section 204(d) of the act, which requires that the Department prepare forms necessary to enforce the requirements of that section. Form LIBC-756 is to be used when the employe is required to report the receipt of benefits subject to section 204(c) of the act and Form LIBC-750 is to be used when the employe is required to report wages under sections 204(c) and 311.1 of the act. These forms are required by the express language of section 204 of the act.

2. Form LIBC-761, "Notice of Workers' Compensation Benefit Offset," was also created under section 204(d) of the act. This form is to be used by the insurer when notifying an employe that the employe's benefits are to be offset under section 204 of the act.

3. Form LIBC-766, "Request for Designation of a Physician to Perform an Impairment Rating Evaluation," was created to meet the requirement under section 306(a.2)(1) of the act that the Department designate physicians to perform IREs.

4. Form LIBC-767, "Impairment Rating Determination Face Sheet," was created to provide a standardized format for physicians to record specific information obtained under section 306(a.2)(1) and (2) of the act.

5. Form LIBC-765, "Impairment Rating Evaluation Appointment," was created to provide a standardized format for notifying an employe of a forthcoming IRE under section 306(a.2)(1) of the act and to notify the employe of the employe's rights or duties thereunder.

6. Form LIBC-764, "Notice of Change of Workers' Compensation Disability Status," was created to ensure that proper notice is given to the employe, under section 306(a.2)(2) of the act, that the status of the employe's disability has changed.

7. Form LIBC-757, "Notice of Ability to Return to Work," was created under section 306(b)(3) of the act and was designed to notify the employe that the insurer believes that the employe is capable of returning to work. This form is required by the express language of section 306(b)(3) of the act.

8. Form LIBC-760, "Employee Verification of Employment, Self-employment or Change in Physical Condition," was created to provide a means for the insurer to obtain the information contemplated by section 311.1(d) of the act. This form is required by the express language of section 311.1(d) of the act.

9. Form LIBC-762, "Notice of Suspension for Failure to Return Form LIBC-760," was created to notify the employe that the employe's benefits have been suspended because of the employe's failure to return Form LIBC-760 under section 311.1 of the act. Additionally, this form notifies the employe of the employe's rights and remedies regarding the suspension of benefits under section 311.1 of the act.

10. Form LIBC-763, "Notice of Reinstatement of Workers' Compensation Benefits," was created to notify the employe that the employe's benefits have been reinstated after the insurer has received Form LIBC-760, under section 311.1 of the act.

11. Form LIBC-753, "Notice of Request for an Informal Conference," and Form LIBC-754, "Informal Conference Agreement Form," were designed to implement the informal conference procedures of section 402.1 of the act. Form LIBC-753 was created to standardize and simplify

requests for informal conferences before workers' compensation judges or hearing officers. Form LIBC-754 was created to provide a mechanism for the parties to record matters which were agreed upon at the informal conference and to provide a standardized mechanism for the Departmental recordkeeping of these agreements.

12. Form LIBC-751, "Notification of Suspension or Modification Pursuant to §§ 413(C)&(D) of the Workers' Compensation Act," was designed to provide notice to the employe, under section 413(c) and (d) of the act, that the employe's benefits have been suspended or modified because the employe has returned to work. This form is required by the express language of section 413(c) and (d) of the act.

13. Form LIBC-755, "Compromise and Release Agreement by Stipulation Pursuant to Section 449 of the Workers' Compensation Act," was created to provide a means to record all information necessary for a valid compromise and release under section 449 of the act. This form was required by the express language of section 449 of the act.

Sunset Date

No sunset date is necessary for these amendments. These amendments will be continuously monitored, since the Department regularly receives and decides petitions to which these amendments apply in proceedings conducted by workers' compensation judges. Issues regarding the regulations' effectiveness, clarity or impartiality will undoubtedly be raised before the Department in these proceedings. If needed, corrections can be initiated based on information obtained in these proceedings.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on June 28, 1997, the Department submitted a copy of the notice of proposed rulemaking, published at 27 Pa.B. 3141 to IRRC and the Chairpersons of the House Labor Relations Committee and the Senate Committee on Labor and Industry for review and comment. IRRC and the Committees were provided with copies of the comments received during the public comment period, as well as other documents when requested.

In preparing these final-form regulations, the Department has considered all comments received from IRRC, stakeholders and the public.

These final-form regulations were deemed approved by the House and Senate Committees on November 18, 1997. IRRC met on November 20, 1997, and approved the amendments in accordance with section 5(c) of the Regulatory Review Act.

Contact Person

The contact person is Richard A. Himler, Director, Bureau of Workers' Compensation, Department of Labor and Industry, (717) 783-5421, 1171 South Cameron Street, Room 324, Harrisburg, PA 17104.

Findings

The Department finds that:

(1) Public notice of intention to amend the administrative regulations amended by this order has been given under sections 201 and 202 of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. §§ 1201 and 1202) and the regulations thereunder, 1 Pa. Code §§ 7.1 and 7.2.

(2) The amendment of the regulations of the Department in the manner provided in this order is necessary and appropriate for the administration and enforcement of the authorizing statute.

Order

The Department, acting under the authorizing statutes, orders that:

(a) The regulations of the Department, 34 Pa. Code, are amended by deleting §§ 122.1—122.11, 122.101—122.104, 122.201, 122.202, 122.301—122.303, 122.401, 122.501 and 122.502, 127.501—127.515, adding §§ 123.1—123.11, 123.101—123.105, 123.201—123.203, 123.301, 123.302, 123.401—123.404, 123.501, 123.502, 123.601, 123.701 and 131.49—131.51; and by amending §§ 127.105, 127.208, 127.252, 127.401, 127.404, 127.405, 127.451—127.457, 127.465, 127.466, 127.476, 127.477, 127.479, 127.551—127.553, 127.555, 127.556, 127.751, 127.752, 127.755 to read as set forth in Annex A.

(*Editor's Note*: Section 31.2 of Act 57 of 1996 (77 P. S. § 531.1 note) requires that the Legislative Reference Bureau transfer 28 Pa. Code §§ 9.201—9.227 to 34 Pa. Code §§ 122.601—122.627. The transfer will occur in the March 1998 *Pennsylvania Code* Reporter (MTS 280).)

(b) The Secretary shall submit this order and Annex A to the Office of General Counsel and Office of Attorney General for approval as to form and legality as required by law.

(c) The Secretary shall certify this order and Annex A and deposit them with the Legislative Reference Bureau as required by law.

(d) This order shall take effect upon publication in the *Pennsylvania Bulletin*.

JOHNNY J. BUTLER,
Secretary

(*Editor's Note*: The addition of §§ 123.203, 123.402—123.404 and 131.49—131.51 was not included in the proposal at 27 Pa.B. 3141 (June 28, 1997). The amendment of §§ 127.465 and 127.476 was not included in the proposal at 27 Pa.B. 3141. The proposal to add §§ 123.602, 123.603, 123.801 and 123.901, included in the proposed rulemaking at 27 Pa.B. 3141, has been withdrawn by the Department.)

(*Editor's Note*: For the text of the order of the Independent Regulatory Review Commission relating to this document, see 27 Pa.B. 6385 (December 6, 1997).)

Fiscal Note: Fiscal Note 12-50 remains valid for the final adoption of the subject regulations.

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 authorize the offset of workers' compensation benefits by amounts received in unemployment compensation, Social Security (old age), severance and pension benefits, subsequent to the work-related injury. Offsets shall be dollar-for-dollar and calculated as set forth in §§ 123.4—123.11. Offsets in excess of the weekly workers' compensation rate shall accumulate as a credit toward the future payment of workers' compensation benefits.

§ 123.2. Definitions.

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

ADR—Alternative Dispute Resolution.

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

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

CBA—Collective Bargaining Agreements.

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

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

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

IRE—Impairment Rating Evaluation.

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

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

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

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

Social Security (old age) benefits—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, "Employee's Report of Benefits." This includes amounts withdrawn or otherwise utilized from pension benefits which are rolled over into an IRA or other similarly restricted account while at the same time the employe is receiving workers' compensation benefits.

(b) Form LIBC-756 shall be completed and forwarded to the insurer within 30 days of the employe's receipt of any of the benefits specified in subsection (a) or within 30 days of any change in the receipt of the benefits specified in subsection (a), but at least every 6 months.

§ 123.4. Application of the offset generally.

(a) After receipt of Form LIBC-756, the insurer may offset workers' compensation benefits by amounts received by the employe from any of the sources in § 123.3 (relating to employe report of benefits subject to offset). The offset of workers' compensation benefits only applies with respect to amounts of unemployment compensation, Social Security (old age), severance and pension benefits received subsequent to the work-related injury.

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

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

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

(b) At least 20 days prior to taking the offset, the insurer shall notify the employe, on Form LIBC-761, "Notice of Workers' Compensation Benefit Offset," that the workers' compensation benefits will be offset. The notice shall indicate:

(1) The amount of the offset.

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

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

(4) When the offset commences.

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

(c) Whenever the insurer's entitlement to the offset changes, the insurer shall notify the employe of the change at least 20 days prior to the adjustment on Form LIBC-761.

(d) The insurer shall provide a copy of Form LIBC-761, to the employe, the employe's counsel, if known, and the Department. The form shall be provided to the employe consistent with section 406 of the act (77 P. S. § 717).

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

(f) When Federal, State or local taxes are paid with respect to amounts an employe receives in unemployment compensation, Social Security (old age), severance or pension benefits, the insurer shall repay the employe for amounts previously offset, and paid in taxes, from workers' compensation benefits, when the offset was calculated on the pretax amount of the benefit received. To request repayment for amounts previously offset and paid in taxes, the employe shall notify the insurer in writing of the amounts paid in taxes previously included in the offset.

§ 123.5. Offset for benefits already received.

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

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

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

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

§ 123.6. Application of offset for Unemployment Compensation (UC) benefits.

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

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

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

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

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

(d) When an employe receives a lump-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 net amount an employe receives in pension benefits to the extent funded by the employer directly liable for the payment of workers' compensation.

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

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

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

§ 123.9. Application of offset for pension benefits.

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

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

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

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

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

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

(e) The employe shall report the subsequent receipt of pension benefits from the IRA or other similarly restricted account to the insurer on Forms LIBC-756 and LIBC-750, "Employee Report of Wages (Other Than Workers' Compensation Benefits Received)."

§ 123.10. Multiemployer pension fund offsets.

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

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

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

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

§ 123.11. Application of offset for severance benefits.

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

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

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

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

Subchapter B. IMPAIRMENT RATINGS

Sec.

§ 123.101. Purpose.

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

§ 123.102. IRE requests.

(a) During the 60-day period subsequent to the expiration of the employe's receipt of 104 weeks of total disability benefits, the insurer may request the employe's attendance at an IRE. If the evaluation is scheduled to occur during this 60-day time period, the adjustment of the benefit status shall relate back to the expiration of the employe's receipt of 104 weeks of total disability benefits. In all other cases, the adjustment of the disability status shall be effective as of the date of the evaluation or as determined by the evaluating physician.

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

(c) When an insurer requests the employe's attendance at an IRE during the 60-day period subsequent to the expiration of the employe's receipt of 104 weeks of total disability benefits and the employe fails, for any reason, to attend the IRE, when the failure results in the performance of the IRE more than 60 days beyond the expiration of the 104-week period, the adjustment of

disability status shall relate back to the expiration of the employe's receipt of 104 weeks of total disability benefits.

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

(e) The insurer shall request the employe's attendance at the IRE in writing on Form LIBC-765, "Impairment Rating Evaluation Appointment," and specify therein the date, time and location of the evaluation and the name of the physician performing the evaluation, as agreed by the parties or designated by the Department. The request shall be made to the employe and employe's counsel, if known.

(f) Consistent with section 306(a.2)(6) of the act (77 P. S. § 511.2), the insurer's failure to request the evaluation during the 60-day period subsequent to the expiration of the employe's receipt of 104 weeks of total disability benefits may not result in a waiver of the insurer's right to compel the employe's attendance at an IRE.

(g) The insurer maintains the right to request and receive an IRE twice in a 12-month period. The request and performance of IREs may not preclude the insurer from compelling the employe's attendance at independent medical examinations or other expert interviews under section 314 of the act (77 P. S. § 651).

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

§ 123.103. Physicians.

(a) Physicians performing IREs shall:

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

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

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

(c) Physicians chosen by employes to perform IREs, for purposes of appealing a previous adjustment of benefit status, shall possess the qualifications in subsection (a) and shall be active in clinical practice as specified in subsection (b).

(d) In addition to the requirements of subsections (a) and (b), physicians designated by the Department to perform IREs shall meet training and certification requirements which may include, but are not limited to, one or more of the following:

(1) Required attendance at a Departmentally approved training course on the performance of evaluations under the AMA "Guides to the Evaluation of Permanent Impairment."

(2) Certification upon passage of a Departmentally approved examination on the AMA "Guides to the Evaluation of Permanent Impairment."

(3) Other requirements as approved by the Department.

§ 123.104. Initial IRE; designation of physician by Department.

(a) The insurer is responsible for scheduling the initial IRE. Only the insurer may request that the Department designate an IRE physician.

(b) The Department's duty to designate an IRE physician pertains only to the initial IRE. A list of Departmentally approved IRE physicians will be available upon request.

(c) The request to designate a physician shall be made on Form LIBC-766, "Request for Designation of a Physician to Perform an Impairment Rating Evaluation."

(d) Within 20 days of receipt of the designation request, the Department will designate a physician to perform the IRE.

(e) The Department will provide the name and address of the physician designated to perform the IRE to the employe, the insurer and the attorneys for the parties, if known.

§ 123.105. Impairment rating determination.

(a) When properly requested under § 123.102 (relating to IRE requests), an IRE shall be conducted in all cases and an impairment rating determination must result under the most recent edition of the AMA "Guides to the Evaluation of Permanent Impairment."

(b) To ascertain an accurate percentage of the employe's whole body impairment, 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. Any physician chosen by the evaluating physician to assist in ascertaining the percentage of whole body impairment shall possess the qualifications as specified in § 123.103(a) and (b) (relating to physicians). The referring physician remains responsible for determining the whole body impairment rating of the employe.

(c) The physician performing the IRE shall complete Form LIBC-767, "Impairment Rating Determination Face Sheet" (Face Sheet), which sets forth the impairment rating of the compensable injury. The physician shall attach to the Face Sheet the "Report of Medical Evaluation" as specified in the AMA "Guides to the Evaluation of Permanent Impairment." The Face Sheet and report shall be provided to the 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 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 Form LIBC-764, "Notice of Change in Workers' Compensation Disability Status," of the following:

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

(2) Sixty days from the date of the notice the 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) 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.

(e) If the evaluation results in an impairment rating that is equal to or greater than 50%, the employe shall be

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

(f) At any time during the receipt of 500 weeks of partial disability compensation, the 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.
123.203. Credibility determinations.

§ 123.201. Purpose.

This subchapter interprets 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 purpose 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 Experts.

(B) The Commission on Rehabilitation Counselor Certification.

(C) The Commission on Disability Management Specialists Certification.

(D) The National Board of Certified Counselors.

(E) Other Nationally recognized professional organizations approved by the Department.

(ii) One year experience in analyzing labor market information and conditions, industrial and occupational trends, with primary duties providing actual vocational rehabilitation services, which include the following:

(A) Job seeking skills.

(B) Job development.

(C) Job analysis.

(D) Career exploration.

(E) Placement of individuals with disabilities.

(F) Vocational testing and assessment.

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

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

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

(i) Job seeking skills.

(ii) Job development.

(iii) Job analysis.

(iv) Career exploration.

(v) Placement of individuals with disabilities.

(vi) Vocational testing and assessment.

§ 123.203. Credibility determinations.

Credibility determinations relating to the experts contemplated by this subchapter are within the province of the workers' compensation judge.

Subchapter D. EARNING POWER DETERMINATIONS

Sec.
123.301. Employer job offer obligation.
123.302. Evidence of earning power.

§ 123.301. Employer job offer obligation.

(a) For claims for injuries suffered on or after June 24, 1996, if a specific job vacancy exists within the usual employment area within this Commonwealth with the liable employer, which the 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 section 306(b)(3) of the act (77 P. S. § 512(b)(3)) and shall continue for 30 days or until the filing of a Petition for Modification or Suspension, whichever is longer. When an insurer files a Petition for Modification or Suspension which is not based upon a change in medical condition, the employer's obligation to offer a specific job vacancy commences at least 30 days prior to the filing of the petition.

(c) The employer's duty under subsections (a) and (b) may be satisfied if the employer demonstrates facts which may include the following:

(1) The 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.

(d) 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.

(e) The employer's duty under subsections (a) and (b) does not require the employer to hold a job open for a minimum of 30 days. Job offers shall be made consistent with the employer's usual business practice. If the making of job offers is controlled by the provisions of a

collective bargaining agreement, the offer shall be made consistent with those provisions.

(f) If the employer has presented evidence that no job vacancy exists, the employe may rebut the employer's evidence by demonstrating facts which may include the following:

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

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

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

§ 123.302. Evidence of earning power.

For claims for injuries suffered on or after June 24, 1996, an insurer may demonstrate an employe's earning power by providing expert opinion evidence relative to the employe's capacity to perform a job. The evidence shall include job listings with agencies of the Department, private job placement agencies and advertisements in the usual employment area within this Commonwealth. Partial disability applies if the employe is able to perform his previous work, or can, considering the employe's residual productive skill, education, age and work experience, engage in any other kind of substantial gainful employment in the usual employment area in which the employe lives within this Commonwealth. If the employe does not live within this Commonwealth, the usual employment area where the injury occurred applies.

Subchapter E. COLLECTIVE BARGAINING

Sec.
123.401. Use of ADR systems.
123.402. Forms and filing requirements.
123.403. Effect of creation, continuation and termination of ADR systems.
123.404. Effect and appeal of ADR final determinations.

§ 123.401. Use of ADR systems.

CBAs may provide for the use of an ADR system which may include arbitration, mediation and conciliation, for the resolution of claims for work-related injuries.

§ 123.402. Forms and filing requirements.

(a) If the employer and the recognized or certified and exclusive representative of its employes agree to establish an ADR system, a copy of the portion of the CBA which establishes the ADR system shall be provided to the Governor's Office of Labor-Management Cooperation in the Department.

(b) The standard forms and filing requirements of the act which reflect the voluntary action or agreement of the parties remain in effect for parties participating in an ADR system under section 450 of the act (77 P. S. § 1000.6). The forms exclusively pertaining to filings before a workers' compensation judge are inapplicable to parties participating in an ADR system.

(c) Documents submitted to the Department under this subchapter shall clearly indicate, by notation on the top page of the document, that a section 450 ADR system governs the disposition of the matter.

(d) Final determinations rendered by means of an ADR system shall be documented and a copy of the determination shall be submitted to the parties and to the Department.

§ 123.403. Effect of creation, continuation and termination of ADR systems.

(a) Once established by a CBA, an ADR system shall be the exclusive system for resolving claims for work-related injuries during the existence of the CBA or longer, if the CBA provides for the continued operation of the ADR system at the expiration of the CBA.

(b) When an ADR system governing a work-related injury is no longer in effect, resolution of claims shall be fully subject to the act, including review by a workers' compensation judge.

§ 123.404. Effect and appeal of ADR final determinations.

(a) Final determinations rendered under an ADR system are binding and enforceable.

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

Subchapter F. EMPLOYE REPORTING AND VERIFICATION REQUIREMENTS

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 the employe with the forms required to fulfill the employe's reporting and verification requirements under section 311.1(d) of the act.

§ 123.502. Verification.

(a) Insurers may submit Form LIBC-760, "Employee Verification of Employment, Self-employment or Change in Physical Condition," to the employe and employe's counsel, if known, to verify, no more than once every 6 months, that the status of the employe's entitlement to receive compensation has not changed.

(b) Form LIBC-760 shall be delivered to the employe in person or consistent with section 406 of the act.

(c) The employe shall complete and return form LIBC-760 to the insurer within 30 days of receipt of the form.

(d) If the employe fails to comply with subsection (c), the insurer may suspend payments of wage-loss benefits until Form LIBC-760 is returned by the employe.

(e) To suspend payments of compensation due to the employe's failure to comply with subsection (c), the insurer shall provide written notice to the 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 or 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 30-day statutorily prescribed time period.

(2) The workers' compensation benefits shall be reinstated by the insurer, effective upon receipt of the completed verification form.

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

(f) Upon receipt of the completed verification form, the insurer shall reinstate the workers' compensation benefits for which the 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 the workers' compensation benefits.

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

Subchapter G. INFORMAL CONFERENCE

Sec.
123.601. Representation of corporation at informal conference.

§ 123.601. Representation of corporation at informal conference.

Each party may be represented at the informal conference conducted under section 402.1 of the act (77 P. S. § 711.1), but the employer may only be represented by an attorney at the informal conference if the employe is also represented by an attorney. When the employe is not represented at the informal conference, an employer may be represented by an agent or other representative, other than an attorney, at the informal conference.

Subchapter H. USE OF OPTICALLY SCANNED DOCUMENTS

Sec.
123.701. Use of optically scanned documents.

§ 123.701. Use of optically scanned documents.

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

(b) Copies made under this section, and certified by the custodian of records for the Bureau, are admissible in evidence in a proceeding with the same effect as though they were an original.

CHAPTER 127. WORKERS' COMPENSATION MEDICAL COST CONTAINMENT CALCULATIONS

Subchapter B. MEDICAL FEES AND FEE REVIEW

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

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

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

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

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

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

BILLING TRANSACTION

§ 127.208. Time for payment of medical bills.

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

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

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

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

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

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

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

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

(a) Providers seeking review of fee disputes shall file the original and one copy of a form prescribed by the Bureau as an application for fee review. The application shall be filed no more than 30 days following notification

of a disputed treatment or 90 days following the original billing date of the treatment which is the subject of the fee dispute, whichever is later. The form shall be accompanied by documentation required by § 127.253 (relating to application for fee review—documents required generally).

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

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

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

Subchapter C. MEDICAL TREATMENT REVIEW

UR GENERAL REQUIREMENTS

§ 127.401. Purpose/review of medical treatment.

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

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

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

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

§ 127.404. Prospective, concurrent and retrospective review.

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

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

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

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

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

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

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

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

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

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

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

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

UR—REQUEST INITIAL

§ 127.451. Requests for UR—who may file.

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

§ 127.452. Requests for UR—filing and service.

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

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

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

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

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

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

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

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

§ 127.454. Requests for UR—reassignment.

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

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

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

§ 127.455. Requests for UR—conflicts of interest.

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

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

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

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

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

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

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

§ 127.456. Requests for UR—withdrawal.

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

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

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

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

§ 127.457. Time for requesting medical records.

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

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

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

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

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

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

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

(a) Each determination rendered by a URO on the merits shall include a form prescribed by the Bureau as a medical treatment review determination face sheet and the reviewer's report. The face sheet shall be signed by an authorized representative of the URO.

(b) When a determination is rendered against the provider under review on the basis that no records were supplied by the provider, the determination shall consist only of the face sheet. However, in these cases, the face sheet shall clearly indicate that the basis for the decision is the failure of the provider under review to supply records to the URO.

(c) The URO's determination, consisting of both the face sheet and the reviewer's report, shall be served on the employe, the insurer or employer, the provider under review, the attorneys for the parties, if known, and the Bureau.

(d) The URO shall also serve a copy of a petition for review of a UR determination on all parties and their attorneys, if known.

(e) Service shall be made by certified mail, return receipt requested and shall be made on the same date as is entered on the appropriate line of the face sheet.

§ 127.477. Payment for request for UR.

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

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

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

§§ 127.501—127.515. (Reserved).

UR-PETITION FOR REVIEW

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subchapter D. EMPLOYER LIST OF DESIGNATED PROVIDERS

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

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

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

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

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

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

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

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

§ 127.752. Contents of list of designated health care providers.

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

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

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

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

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

(d) If the employer lists a CCO, as an option on the list of designated providers, the employer may not individually list any provider participating in that CCO, under

circumstances when those individually listed providers are bound by the terms of the CCO for the treatment rendered to the injured workers.

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

§ 127.755. Required notice of employe rights and duties.

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

(b) The contents of the written notice shall, at a minimum, contain the following conditions:

(1) The employe has the duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.

(2) The employe has the right to have all reasonable medical supplies and treatment related to the injury paid for by the employer as long as treatment is obtained from a designated provider during the 90-day period.

(3) The employe has the right, during this 90-day period, to switch from one health care provider on the list to another provider on the list, and that all the treatment shall be paid for by the employer.

(4) The employe has the right to seek treatment from a referral provider if the employe is referred to him by a designated provider, and the employer shall pay for the treatment rendered by the referral provider.

(5) The employe has the right to seek emergency medical treatment from any provider, but that subsequent nonemergency treatment shall be by a designated provider for the remainder of the 90-day period.

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

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

(8) The employe has the duty to notify the employer of treatment by a nondesignated provider within 5 days of the first visit to that provider. The employer may not be required to pay for treatment rendered by a nondesignated provider prior to receiving this notification. However, the employer shall pay for these services once notified, unless the treatment is found to be unreasonable by a URO, under Subchapter C (relating to medical treatment review).

(9) The 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 90 days from the date of the first visit to the provider of the additional opinion.

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

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

CHAPTER 131. SPECIAL RULES OF ADMINISTRATIVE PRACTICE AND PROCEDURE BEFORE REFEREES

Subchapter C. FORMAL PROCEEDINGS

SUPERSEDEAS

Sec.

§ 131.49. 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 judge 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, unless the employe establishes by a preponderance of the evidence a likelihood of prevailing on the merits of the employe's defense. 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. The automatic re-

quest for supersedeas shall remain denied until the judge issues a written order granting the supersedeas, in whole or in part.

§ 131.50. 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 Suspension or Modification Pursuant to §§ 413(C) & (D)." The form 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 and § 774.3), to effectuate a subsequent modification or suspension of the employe's workers' compensation benefits, the insurer shall file the form under subsection (b), indicating the change in the employe's wages and corresponding change in the employe's workers' compensation benefits.

§ 131.51. Employe request for special supersedeas hearing under section 413(c) and (d) of the act.

(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.

[Pa.B. Doc. No. 98-116. Filed for public inspection January 16, 1998, 9:00 a.m.]