CHAPTER 127. WORKERS' COMPENSATION MEDICAL COST CONTAINMENT

Authority

The provisions of this Chapter 127 issued under sections 306(f.1), 401.1, 420(a) and 435 of the Workers' Compensation Act (77 P. S. § § 531(f.1), 710, 831(a) and 991), unless otherwise noted.

Source

The provisions of this Chapter 127 adopted November 10, 1995, effective November 11, 1995, 25 Pa.B. 4873, unless otherwise noted.

Subchapter A. PRELIMINARY PROVISIONS

Sec.

§ 127.1. Purpose.

This chapter implements those sections of the act that relate to payments made by insurers or self-insured employers for medical treatment and the review of medical treatment provided to employes with work-related injuries and illnesses.

§ 127.2. Computation of time.

Unless otherwise provided, references to ''days'' in this chapter mean calendar days. For purposes of determining timeliness of filing and receipt of documents transmitted by mail, 3 days shall be

presumed added to the prescribed period. If the last day for filing a document is a Saturday, Sunday or legal holiday, the time for filing shall be extended to the next business day. Transmittal by mail means by first-class mail.

§ 127.3. Definitions.

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

ASC—Ambulatory Surgery Center—A center that operates exclusively for the purpose of furnishing outpatient surgical services to patients. These facilities are referred to by HCFA as ASCs and by the Department of Health as ASFs. For consistency with the application of Medicare regulations, these facilities are referred to in this chapter as ASCs.

ASF—Ambulatory Surgical Facility—An ASC.

Accredited speciality board—A speciality board recognized by the American Board of Medical Specialties, the American Osteopathic Association or by the Chiropractic Council on Education.

Act—The Workers' Compensation Act (77 P. S. § § 1—1041.4).

Act 44—The act of July 2, 1993 (P. L. 190, No. 44).

Actual charge—The provider's usual and customary charge for a specific treatment, accommodation, product or service.

Acute care—The inpatient and outpatient hospital services provided by a facility licensed by the Department of Health as a general or tertiary care hospital, other than a specialty hospital, such as rehabilitation and psychiatric provider.

Approved teaching program—A hospital teaching program which is accredited in its field by the appropriate approving body to provide graduate medical education or paramedical education services, or both. Accreditation for medical education programs shall be as recognized by one of the following:

(i) The Accreditation Council for Graduate Medical Education of the American Medical Association.

(ii) The Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association.

(iii) The Council on Dental Education of the American Dental Association.

(iv) The Council of Podiatric Medicine Education of the American Podiatric Association.

(v) An appropriate approving body of paramedical educational and training programs.

Audited Medicare cost report—The Medicare cost report, settled by the Medicare fiscal intermediary through the conduct of either a field audit or desk review resulting in the issuance of the Notice of Program Reimbursement.

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

Burn facility—A facility which meets the service standards of the American Burn Association.

CCO—Coordinated Care Organization—An organization certified under Act 44 by the Secretary of Health for the purpose of providing medical services to injured employes.

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

CPT-4—The physician's ''Current Procedural Terminology, Fourth Edition,'' as defined and published by the American Medical Association.

Capital related cost—The health care provider's expense related to depreciation, interest, insurance and property taxes on fixed assets and moveable equipment.

Charge master—A provider's listing of current charges for procedures and supplies utilized in the provider's billing process.

Commissioner—The Insurance Commissioner of the Commonwealth.

DME—Durable medical equipment—The term includes iron lungs, oxygen tents, hospital beds and wheelchairs (which may include a power-operated vehicle that may be appropriately used as wheelchair) used in the patient's home or in an institution, whether furnished on a rental basis or purchased.

DRG—Diagnostic related groups.

Department—The Department of Labor and Industry of the Commonwealth.

Direct medical education cost—The salaries and other expenses related to the provider's resident and intern graduate medical education approved teaching program. This amount includes the allocable overhead costs associated with the provider's maintenance and administration of the resident and intern programs.

Disproportionate share hospital—A hospital providing acute care that serves a significantly disproportionate share of low-income patients.

Fully prospective—Inpatient capital-related cost of an acute care provider included in the DRG payment based on a blend of hospital-specific data and Federal data and excluded from cost report settlements.

HCFA—The Health Care Financing Administration.

HCPCS—HCFA Common Procedure Coding System—The procedure codes and associated nomenclature consisting of numeric CPT-4 codes, and alpha-numeric codes, as developed both Nationally by HCFA and on a Statewide basis by local Medicare carriers.

Health care provider—A person, corporation, facility or institution licensed, or otherwise authorized, by the Commonwealth to provide health care services, including physicians, coordinated care organizations, hospitals, health care facilities, dentists, nurses, optometrists, podiatrists, physical therapists, psychologists, chiropractors, or pharmacists, and officers, employes or agents of the person acting in the course and scope of employment or agency related to health care services.

Hold harmless—Inpatient capital-related cost of an acute care provider which can either be included fully in the DRG payment or partially included in both the DRG and cost-reimbursed payment.

(i) One hundred percent hold harmless means inpatient capital-related cost included fully in the DRG payment at 100% of the Federal capital rate.

(ii) Blended hold harmless means inpatient capital-related cost included in the DRG payment for assets acquired after December 31, 1990, and cost-reimbursed for assets acquired before December 31, 1990.

(iii) Capital-exceptional hospital means a provider receiving payment from Medicare based on cost because payments at either the fully prospective rate or the hold harmless rates are less than or equal to 70% of the provider's payments based on cost.

ICD-9-CM—(ICD-9) The International Classification of Diseases—Ninth Edition—Clinical Modification

Indirect medical education cost—The expenses related to the use of additional ancillary services and consumption of provider resources related to the provision of a graduate medical education approved teaching program.

Insurer—A workers' compensation insurance carrier, including the State Workmen's Insurance Fund, an employer who is authorized by the Department to self-insure its workers' compensation liability under section 305 of the act (77 P. S. § 501), or a group of employers authorized by the Department to act as a self-insurance fund under section 802 of the act (77 P. S. § 1036.2).

Interim rate notification—The letter, from the Medicare intermediary to the provider, informing the provider of their interim payment rate and its effective date.

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

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

Medicare intermediary—An organization with a contractual relationship with HCFA to process Medicare Part A or Part B claims.

Medicare Part A—Medicare hospital insurance benefits which pay providers for facility-based care, such as care provided in inpatient general and tertiary hospitals, specialty hospitals, home health agencies and skilled nursing facilities.

Medicare Part B—Medicare supplementary medical insurance which pays providers for physician services, outpatient hospital services, durable medical equipment, physical therapy and other services.

NPR—Notice of program reimbursement—The letter of notification from the Medicare intermediary to the provider regarding the final settlement of the Medicare cost report.

New provider—A provider which began administering patient care after receiving initial licensure on or after August 31, 1993.

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

Notice of per resident amount—The letter of notification from the Medicare intermediary to the

provider, informing the provider of the annual payment amount per resident or intern full-time equivalent.

PRO—Peer Review Organization—An organization authorized by the Secretary for the purpose of determining the necessity or frequency of medical treatment administered to workers with work-related injuries.

Paramedical education cost—The education cost related to providers' nongraduate medical education programs including nursing school programs, radiology and laboratory technology training programs and other allied health professional approved teaching programs.

Pass-through costs—Medicare reimbursed costs to a hospital that ''pass through'' the prospective payment system and are not included in the DRG payments.

Provider—A health care provider.

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

Secretary—The Secretary of the Department.

Specialty hospital—A health care facility licensed and approved by the Department of Health as a hospital providing either a comprehensive inpatient rehabilitation program or an acute psychiatric inpatient program.

Transition fee schedule—The Medicare payment amounts as determined by the Medicare carrier, based on the transition rules requiring a blend of the full fee schedule (full implementation of the Resource Based Relative Value Scale, RBRVS) and the original provider fee schedule.

Trauma center—A facility accredited by the Pennsylvania Trauma Systems Foundation under the Emergency Medical Services Act (35 P. S. § § 6921—6938).

UR—Utilization Review.

URO—Utilization Review Organization—An organization authorized by the Secretary for the purpose of determining the reasonableness or necessity of medical treatment administered to workers with work-related injuries.

Unbundling—The practice of separate billing for multiple service items or procedures instead of grouping the services into one charge item.

Urgent injury—As defined by the American College of Surgeons' triage guidelines regarding use of trauma centers for the region where the services are provided.

Usual and customary charge—The charge most often made by providers of similar training, experience and licensure for a specific treatment, accommodation, product or service in the geographic area where the treatment, accommodation, product or service is provided.

Workers' Compensation judge—As defined by section 401 of the act (77 P. S. § 701) (definition of ''referee'') and as appointed by the Secretary.

Subchapter B. MEDICAL FEES AND FEE REVIEW

CALCULATIONS

Sec.

MEDICAL FEE UPDATES

BILLING TRANSACTIONS

REVIEW OF MEDICAL FEE DISPUTES

SELF-REFERRALS

CALCULATIONS

§ 127.101. Medical fee caps—Medicare.

(a) Generally, medical fees for services rendered under the act shall be capped at 113% of the Medicare reimbursement rate applicable in this Commonwealth under the Medicare Program for comparable services rendered. The medical fees allowable under the act shall fluctuate with changes in the applicable Medicare reimbursement rates for services rendered prior to January 1, 1995. Thereafter, for services rendered on and after January 1, 1995, medical fees shall be updated only in accordance with § § 127.151—127.162 (relating to medical fee updates).

(b) Medicare coinsurance and deductibles may not be used to reduce the allowable fee under the act.

(c) If a provider's actual charges for services rendered are less than the maximum fee allowable under the act, the provider shall be paid only the actual charges for the services rendered.

(d) The Medicare reimbursement mechanisms that shall be used when calculating payments to providers under the act are set forth in § § 127.103—127.128.

(e) Medical fee caps based on Medicare will apply to all health care providers licensed in this Commonwealth who treat injured workers, regardless of whether the health care provider participates in the Medicare Program.

(f) An insurer may not make payment in excess of the medical fee caps, unless payment is made pursuant to a contract with a CCO certified by the Secretary of Health.

Notes of Decisions

Third-Party Insurers

Where claimant's employer initially denied that her injury was work-related and she proceeded with surgery, which was paid for by her third-party insurer, the third-party insurer was entitled to the full amount paid even if that amount exceeded 113% of the Medicare reimbursement rate. *Furnival State Machinery/Transamerica Insurance Group v. Workers' Compensation Appeal Board* (SLYE), 757 A.2d 433 (Pa. Cmwlth. 2000); appeal denied 771 A.2d 1289 (Pa. 2001).

§ 127.102. Medical fee caps—usual and customary charge.

If a Medicare payment mechanism does not exist for a particular treatment, accommodation, product or service, the amount of the payment made to a health care provider shall be either 80% of the usual and customary charge for that treatment, accommodation, product or service in the geographic area where rendered, or the actual charge, whichever is lower.

§ 127.103. Outpatient providers subject to the Medicare fee schedule—generally.

(a) When services are rendered by outpatient providers who are reimbursed under the Medicare Part B Program pursuant to the Medicare fee schedule, the payment under the act shall be calculated using the Medicare fee schedule as a basis. The fee schedule for determining payments shall be the transition fee schedule as determined by the Medicare carrier.

(b) The insurer shall pay the provider for the applicable Medicare procedure code even if the service in question is not a compensated service under the Medicare Program.

(c) If a Medicare allowance does not exist for a reported HCPCS code, or successor codes, the provider shall be paid either 80% of the usual and customary charge or the actual charge, whichever is lower.

(d) When calculating payment for all services rendered on and before December 31, 1995, all rate increases, periodic adjustments and modifications incorporated into the Medicare Part B Fee Schedule shall be used. The effective date of these changes under Medicare shall also be the effective date of the fee changes under the act, as provided in § 127.151 (relating to medical fee updates prior to January 1, 1995—generally).

(e) Fee updates subsequent to December 31, 1994, shall be in accordance with § § 127.152 and 127.153 (relating to medical fee updates on and after January 1, 1995—generally; and medical fee updates on and after January 1, 1995—outpatient providers, services and supplies subject to the Medicare fee schedule).

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.119 (relating to payments for services using RCCs); 34 Pa. Code § 127.126 (relating to new providers); 34 Pa. Code § 127.153 (relating to medical fee updates on and after January 1, 1995—outpatient providers, services and supplies subject to the Medicare fee schedule).

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

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

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.106 (relating to outpatient providers subject to the Medicare fee schedule—spinal manipulation performed by Doctors of Osteopathic Medicine); 34 Pa. Code § 127.119 (relating to payments for services using RCCs); 34 Pa. Code § 127.153 (relating to medical fee updates on and after January 1, 1995—outpatient providers, services and supplies subject to the Medicare fee schedule).

§ 127.105. 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).

Source

The provisions of this § 127.105 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial pages (203453) to (203454).

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.153 (relating to medical fee updates on and after January 1, 1995—outpatient providers, services and supplies subject to the Medicare fee schedule).

§ 127.106. Outpatient providers subject to the Medicare fee schedule—spinal manipulation performed by Doctors of Osteopathic Medicine.

(a) Payments for spinal manipulation procedures by Doctors of Osteopathic Medicine shall be based on the Medicare fee schedule for HCPCS codes M0702—M0730 (through 1993) or HCPCS codes 98925—98929 (1994 and thereafter), multiplied by 113%.

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

(c) Payments for other services provided by Doctors of Osteopathic Medicine shall be calculated as provided for in § 127.104 (relating to outpatient providers subject to the Medicare fee schedule—physicians).

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.153 (relating to medical fee updates on and after January 1, 1995—outpatient providers, services and supplies subject to the Medicare fee schedule).

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

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

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.153 (relating to medical fee updates on and after January 1, 1995—outpatient providers, services and supplies subject to the Medicare fee schedule).

§ 127.108. Durable medical equipment and home infusion therapy.

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

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.153 (relating to medical fee updates on and after January 1, 1995—outpatient providers, services and supplies subject to the Medicare fee schedule).

§ 127.109. Supplies and services not covered by fee schedule.

Payments for supplies provided over those included with the billed office visit shall be made at 80% of the provider's usual and customary charge when the provider supplies sufficient documentation to support the necessity of those supplies. Supplies included in the office visit code by Medicare may not be fragmented or unbundled in accordance with § 127.204 (relating to fragmenting or unbundling of charges by providers).

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare).

§ 127.110. Inpatient acute care providers—generally.

(a) Payments to providers of inpatient acute care hospital services shall be based on the sum of the following:

(1) One hundred thirteen percent of the DRG payment.

(2) One hundred percent of payments that are reimbursed on the prospective payment system, as listed in subsection (b).

(3) One hundred percent of pass-through costs.

(4) One hundred percent of applicable cost outliers or 100% of applicable day outliers.

(b) In calculating the payment due, the following payments, which are reimbursed on a prospective payment basis by the Medicare Program, shall be multiplied by 100%:

(1) The prospective portions of capital-related costs relating to payments to the following:

(i) Fully-prospective hospitals.

(ii) Hold-harmless hospitals reimbursed at 100% of the Federal rate (100% hold harmless).

(iii) Blended hold-harmless hospitals.

(2) Direct medical education costs.

(3) Indirect medical education costs.

(c) In calculating the payment due, the following costs, which are reimbursed on a cost basis by the Medicare Program, shall be multiplied by 100%:

(1) The cost portions of capital-related costs relating to the following:

(i) Blended hold-harmless hospitals.

(ii) Capital-exceptional hospitals.

(2) Paramedical education costs.

(3) Cost outliers or day outliers.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.154 (relating to medical fee updates on and after January 1, 1995—inpatient acute care providers subject to DRGs plus add-on payments).

§ 127.111. Inpatient acute care providers—DRG payments.

(a) Payments to providers of inpatient hospital services, whose Medicare Program payments are based on DRGs, shall be calculated by multiplying the established DRG payment on the date of discharge by 113%.

(b) For discharges on and before December 31, 1994, the DRG payments, using the Medicare DRG methodology, shall be based on the most recently published tables of payments, relative values, wage indices, geographic adjustment factors, rural and urban designations and other applicable Medicare payment adjustments published in the *Federal Register*. The effective date for these changes under the Medicare Program shall also be the effective date for the changes under the act.

(c) If the amount of the DRG reimbursement changes during a patient's stay, the applicable reimbursement rate on the date of discharge shall be used to calculate payment under the act.

(d) If a patient was admitted prior to August 31, 1993, the act's medical fee caps may not apply.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.154 (relating to medical fee updates on and after January 1, 1995—inpatient acute care providers subject to DRGs plus add-on payments).

§ 127.112. Inpatient acute care providers—capital-related costs.

(a) An additional payment shall be made to providers of inpatient hospital services for the capital-related costs reimbursed under the Medicare Part A Program.

(b) Hospitals, which have a hospital-specific capital rate lower than the Federal capital rate (fully-prospective), shall be paid for capital-related costs as follows: the hospital's capital rate, as determined by the Medicare intermediary, shall be multiplied by the DRG relative weight on the date of discharge.

(c) Hospitals, which have a hospital-specific capital rate equal to or higher than the Federal capital rate (hold-harmless), shall be paid for capital-related costs as follows:

(1) Hospitals paid at 100% of the Federal capital rate shall receive the Federal capital rate, as determined by the Medicare intermediary, multiplied by the DRG relative weight on the date of discharge.

(2) Hospitals paid at a rate greater than 100% of the Federal capital rate shall be paid on the basis of the most recent notice of interim payment rates as determined by the Medicare intermediary. Hospitals shall receive the new Federal capital rate multiplied by the DRG relative weight on the date of the discharge plus the old Federal capital rate as determined by the Medicare intermediary.

(d) Capital-exceptional hospitals, or new hospitals within the first 2 years of participation in the Medicare Program, shall be paid for capital-related costs as follows: the most recent interim payment rate for capital-related costs, as determined by the Medicare intermediary, shall be added to the DRG payment on the date of discharge.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.154 (relating to medical fee updates on and after January 1, 1995—inpatient acute care providers subject to DRGs plus add-on payments).

§ 127.113. Inpatient acute care providers—medical education costs.

(a) Providers of inpatient hospital services shall receive an additional payment in recognition of the costs of medical education as provided pursuant to an approved teaching program and as reimbursed under the Medicare Program. For providers with an approved teaching program in place prior to January 1, 1995, the medical education add-on payment shall be based on the following calculations:

(1) Payments for direct medical education costs shall be based on figures from the latest audited Medicare cost report and calculated as follows: the medical education cost (Worksheet E, Part IV, Column 1, Line 18) shall be divided by total hospital DRG payments (Worksheet E, Part A, Column 1). This amount shall then be multiplied by the DRG payment on the date of discharge.

(2) Payments for indirect medical education costs shall be calculated as follows: the add-on percentage, identified in the provider's latest Medicare interim rate notification, multiplied by the DRG payment on the date of discharge.

(3) Payments for paramedical education costs shall be calculated by determining the ratio of Medicare paramedical education costs to Medicare DRG payments. This ratio shall then be multiplied by the DRG payment on the date of discharge. The necessary ratio shall be computed as follows:

(i) If the most recently audited Medicare cost report is for a fiscal year beginning on or after October 1, 1991, and uses HCFA Form 2552-92, then the ratio shall be determined by taking the

sum of Lines 14 and 15 on Worksheet E, Part A and dividing it by Line 1.

(ii) If the most recently audited Medicare cost report is for a fiscal year beginning before October 1, 1991, and uses HCFA Form 2552-89, then the ratio shall be determined by taking the sum of medical education costs from Worksheet D, Part I, Column 5, Line 101 and Worksheet D, Part II, Column 5, Line 101 and dividing the sum by total charges from Worksheet D, Part II, Column 7, Line 101; multiplying this amount by Medicare charges from Worksheet D, Part II, Column 9, Line 101; and dividing this amount by DRG payments from Worksheet E, Part A, Line 1.

(b) If a hospital loses its right to receive add-on payments for medical education costs under the Medicare Program, it shall also lose its right to receive the corresponding add-on payments for medical education costs under the act, commencing with services rendered on or after January 1 of the year succeeding the change in status. The hospital shall notify the Bureau in writing of this change in status on or before November 30 of the year in which the hospital has lost the right to receive a medical education add-on payment.

(c) On and after January 1, 1995, if a hospital begins receiving add-on payments for medical education costs under the Medicare Program, it shall also gain the right to receive add-on payments for medical education costs under the act, commencing with services rendered on or after January 1 of the year succeeding the change in status.

(1) The hospital shall notify the Bureau in writing of this change in status on or before November 30 of the year in which the hospital has gained the right to receive a medical education add-on payment. The notification shall include the following:

(i) Documentation that the medical education costs are incurred as the result of an approved teaching program, as accredited by the appropriate approving body.

(ii) The notice of per resident amount for direct medical education.

(iii) The interim rate notification for indirect medical education.

(iv) The notice of biweekly payment rates received from the Medicare Intermediary.

(v) A complete copy of the most recently audited Medicare cost report as of November 30 of the year in which the hospital gained the right to receive additional payments for medical education costs.

(2) If the hospital gained the right to receive a medical education add-on payment on or after January 1, 1995, the payment shall be based on the following calculations:

(i) Payments for direct medical education costs shall be based on the notice of biweekly payment amount. This amount shall be annualized, multiplied by the ratio of Part A reasonable cost to total reasonable cost from Worksheet E-3, Part IV, Line 15, and divided by total hospital DRG payments from the most recently audited Medicare cost report (Worksheet E, Part A, Column 1, Line 1). This amount shall then be multiplied by the DRG payment on the date of discharge.

(ii) Payments for indirect medical education costs shall be calculated as follows: the add-on percentage, identified in the provider's most recent Medicare interim rate notification for the calendar year in which the approved teaching program commenced, multiplied by the DRG payment on the date of discharge.

(iii) Payments for paramedical education costs shall be based on the notice of biweekly payment amount. This amount shall be annualized, multiplied by the ratio of Part A reasonable cost to total reasonable costs from Worksheet E-3, Part IV, Line 15, and divided by total hospital DRG

payments from the most recently audited Medicare cost report (Worksheet E, Part A, Column 1, Line 1). This amount shall be multiplied by the DRG payment on the date of discharge.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.154 (relating to medical fee updates on and after January 1, 1995—inpatient acute care providers subject to DRGs plus add-on payments).

§ 127.114. Inpatient acute care providers—outliers.

(a) Payments for cost outliers shall be based on the Medicare method for determining eligibility for additional payments as follows: the billed charges will be multiplied by the aggregate ratio of cost-to-charges obtained from the most recently audited Medicare cost report to determine the cost of the claim. This cost of claim shall be compared to the applicable Medicare cost threshold. Cost in excess of the threshold shall be multiplied by 80% to determine the additional cost outlier payment.

(b) Payments to acute care providers, when the length of stay exceeds the Medicare thresholds (''day outliers''), shall be determined by applying the Medicare methodology as follows: the DRG payment plus the capital payments shall be divided by the arithmetic mean of length of stay for that DRG as determined by HCFA to arrive at a per diem payment rate. This rate shall be multiplied by the number of actual patient days for the claim which are in excess of the outlier threshold as determined by HCFA and published in the *Federal Register.* The result is added to the DRG payment.

(c) When the calculations under both subsections (a) and (b) are greater than zero, the outlier payment shall be limited to the lesser of the cost outlier computed in accordance with subsection (a) or the day outlier computed in accordance with subsection (b).

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.154 (relating to medical fee updates on or after January 1, 1995—inpatient acute care providers subject to DRGs plus add-on payments).

§ 127.115. Inpatient acute care providers—disproportionate-share hospitals.

(a) An additional payment shall be made to providers of inpatient hospital services designated by the Medicare Program as disproportionate-share hospitals.

(b) Payments to disproportionate-share hospitals shall be calculated as follows: the add-on percentage identified in the provider's latest Medicare interim rate notification shall be multiplied by the DRG payment on the date of discharge and then multiplied by 113%.

(c) A provider requesting additional payments under the act based on its Medicare designation as a disproportionate-share hospital shall provide evidence of this designation to the insurer.

(d) If a hospital loses its right to receive additional payments as a disproportionate-share hospital under the Medicare Program prior to January 1, 1995, it shall also lose its right to receive additional payments under the act.

(e) Loss of the disproportionate-share designation on and after January 1, 1995, will not result in the loss of this designation for purposes of determining payments under the act.

(f) If a hospital gains the disproportionate-share designation on and after January 1, 1995, it will not be paid according to that designation under the act.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.154 (relating to medical fee updates on and after January 1, 1995—inpatient acute care providers subject to DRGs plus add-on payments).

§ 127.116. Inpatient acute care providers—Medicare-dependent small rural hospitals, sole-community hospitals and Medicare-geographically reclassified hospitals.

(a) Payments for Medicare-dependent small rural hospitals, sole-community hospitals and Medicare-geographically reclassified hospitals, shall be calculated as follows: the hospital's payment rate identified on the latest Medicare interim rate notice shall be multiplied by the DRG payment on the date of discharge and then multiplied by 113%.

(b) A provider requesting additional payments under the act based on one of the special designations in subsection (a) shall provide evidence of this Medicare designation to the insurer.

(c) If a hospital loses its designation as a Medicare-dependent small rural hospital, sole-community hospital or Medicare-geographically reclassified hospital under the Medicare Program prior to January 1, 1995, it shall also lose the designation and the right to receive additional payments under the act.

(d) Loss of one of the special designations in subsection (a) on and after January 1, 1995, will not result in the loss of the designation for purposes of determining payments under the act.

(e) If a hospital gains designation as a Medicare-dependent small rural hospital, sole-community hospital or Medicare-geographically reclassified hospital under the Medicare Program on and after January 1, 1995, it will not be paid according to that designation under the act.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.154 (relating to medical fee updates on and after January 1, 1995—inpatient acute care providers subject to DRGs plus add-on payments).

§ 127.117. Outpatient acute care providers, specialty hospitals and other cost-reimbursed providers not subject to the Medicare fee schedule.

The following services shall be paid on a cost-reimbursed basis for medical treatment rendered under Act 44:

(1) Outpatient services of general acute care providers and specialty hospitals reimbursed by Medicare using the HCFA Form 2552 or any successor form.

(2) Inpatient services provided in specialty hospitals and distinct part rehabilitation and psychiatric units of general acute care hospitals, which are exempt from the DRG reimbursement methodology and are reimbursed by Medicare using the HCFA Form 2552 or any successor form.

(3) Services provided in Comprehensive Outpatient Rehabilitation Facilities reimbursed by Medicare using the HCFA Form 2088 or any successor form.

(4) Services provided in outpatient therapy centers electing cost reimbursement for Medicare using the HCFA Form 2088 or any successor form.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.118 (relating to RCCs—generally); 34 Pa. Code § 127.119 (relating to payments for services using RCCs); 34 Pa. Code § 127.120 (relating to RCCs—comprehensive outpatient rehabilitation facilities (CORFs) and outpatient physical therapy centers); 34 Pa. Code § 127.126 (relating to new providers); 34 Pa. Code § 127.155 (relating to medical fee updates on and after January 1, 1995—outpatient acute care providers, specialty hospitals and other cost-reimbursed providers).

§ 127.118. RCCs—generally.

Payments for services listed in § 127.117 (relating to outpatient acute care providers, specialty hospitals and other cost reimbursed providers not subject to the Medicare fee schedule) shall be based on the provider's specific Medicare departmental RCC for the specific services or procedures performed. For treatment rendered on and before December 31, 1994, the provider's latest audited Medicare cost report, with an NPR date preceding the date of service, shall provide the basis for the RCC.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.107 (relating to outpatient providers subject to Medicare fee schedule—physical therapy centers and independent physical therapists).

§ 127.119. Payments for services using RCCs.

(a) Payments for services listed in § 127.117(1) (relating to outpatient acute care providers, specialty hospitals and other cost reimbursed providers not subject to the Medicare fee schedule) shall be calculated as follows: the provider charge shall be multiplied by the applicable RCC, which then shall be multiplied by 113%.

(b) The RCC to be used for providers receiving payment for outpatient services under the RCC methodology shall be the same RCC used by the Medicare Program for determining reimbursement. For providers with audited cost reports using HCFA Form 2552-89 or earlier, Worksheet C, Part II, Column 10 is to be used. For providers with audited cost reports using HCFA Form 2552-92, Worksheet C, Part II, Column 8 is to be used.

(c) Payments for inpatient services listed in § 127.117(2) shall be calculated as follows:

(1) Inpatient routine services shall be reimbursed based on the inpatient routine cost per diem from the most recently audited Medicare cost report, HCFA Form 2552-89 or 2552-92, Worksheet D-1, Part II, Line 38. The routine cost per diem shall be updated by the TEFRA (Tax Equity and Fiscal Responsibility Act of 1982) target rate of increase as published by HCFA in the *Federal Register*. The applicable update shall be applied cumulatively based on the annual update factors published subsequent to the date of the audited cost report year end and prior to December 31, 1994.

(2) Inpatient ancillary services shall be reimbursed based on the provider charge multiplied by the applicable RCC, which then shall be multiplied by 113%.

(d) The RCC to be used for providers receiving payment for inpatient services under the RCC methodology shall be the same RCC used by the Medicare Program for determining reimbursement. For inpatient ancillary costs, using the most recently audited cost report (either the 2552-89 or the 2552-92 HCFA Forms) Worksheet C, Part I, Column 8 is to be used to obtain the RCC.

(e) Services related to clinical laboratory and provider based physicians shall be reimbursed in accordance with § § 127.103 and 127.104 (relating to outpatient providers subject to the Medicare fee schedule—generally; and outpatient providers subject to the Medicare fee schedule—physicians).

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.124 (relating to outpatient and end-stage renal dialysis payment); 34 Pa. Code § 127.126 (relating to new providers).

§ 127.120. RCCs—comprehensive outpatient rehabilitation facilities (CORFs) and outpatient physical therapy centers.

(a) Except as noted in subsection (c), payments for services listed in § 127.117(3) and (4) (relating to outpatient acute care providers, specialty hospitals and other cost reimbursed providers not subject to the Medicare fee schedule) relating to CORFs and outpatient physical therapy centers, shall be calculated as follows: the provider's charge shall be multiplied by the applicable RCC which then shall be multiplied by 113%.

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

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

(1) For providers whose basis of Medicare apportionment is gross charges, the RCC shall be developed by dividing the total departmental cost for each therapy department on line 4 of Schedule C and by the total charges for each therapy department on line 1 of Schedule C. Payments then shall be calculated in accordance with subsection (a).

(2) For providers whose basis of Medicare apportionment is therapy visits, the payment rate shall be based on the average cost per visit, developed by dividing the total departmental cost for each therapy department on line 4 of Schedule C by the total visits for each therapy department on line 1 of Schedule C. Payments for services shall then be calculated as follows: the average cost per visit shall be multiplied by the billed number of visits and then multiplied by 113%.

(3) For providers whose basis of Medicare apportionment is weighted units, the payment rate shall be based on the average cost per weighted unit, developed by dividing the total departmental cost for each therapy department on line 4 of Schedule C by the total weighted units for each therapy department on line 1 of Schedule C. Payments for services shall then be calculated as follows: the average cost per weighted unit shall be multiplied by the billed units and then multiplied by 113%.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.126 (relating to new providers); 34 Pa. Code § 127.155 (relating to medical fee updates on and after January 1, 1995—outpatient acute care providers, specialty hospitals and other cost-reimbursed providers).

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

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

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

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

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

(b) If the cost-reimbursed provider loses its right to receive add-on payments for medical education costs under the Medicare Program, it shall also lost its right to receive add-on payments for medical education costs under the act, commencing with services rendered on or after January 1 of the year succeeding the change in status. The provider shall notify the Bureau in writing of this change in status on or before November 30 of the year in which the provider has lost the right to receive a medical education add-on payment.

(c) On and after January 1, 1995, if the cost-reimbursed provider begins receiving add-on payments for medical education costs under the Medicare Program, it shall also gain the right to receive add-on payments for medical education costs under the act, commencing with services rendered on or after January 1 of the year succeeding the change in status.

(1) The provider shall notify the Bureau in writing of this change on or before November 30 of the year in which the provider has gained the right to receive a medical education add-on payment. The notification shall include the following:

(i) Documentation that the medical education costs are incurred as the result of an approved teaching program, as accredited by the appropriate approving body.

(ii) The notice of per resident amount.

(iii) The notice of biweekly payment rates received from the Medicare intermediary.

(iv) A complete copy of the most recently audited Medicare cost report as of November 30 of the year in which the provider gained the right to receive additional payments for medical education costs.

(2) If the provider gained the right to receive a medical education add-on payment on or after January 1, 1995, the payment shall be based on the notice of biweekly payment amount. This amount shall be annualized and divided by the sum of the hospitals' inpatient and outpatient cost from Supplemental Worksheet E-3, Part IV, Column 1, Line 12.05 and Line 13.03. This ratio shall then be multiplied by the provider's charges, multiplied by the applicable RCC, multiplied by applicable updates and added to the charge master payment rates.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.155 (relating to medical fee updates on and after January 1, 1995—outpatient acute care providers, specialty hospitals and other cost-reimbursed providers).

§ 127.122. Skilled nursing facilities.

Payments to providers of skilled nursing care who file Medicare cost reporting forms HCFA 2540 (freestanding facilities) or HCFA 2552 (hospital based facilities), or any successor forms, shall be calculated as follows: the most recent Medicare interim per diem rate shall be multiplied by the number of patient days and then multiplied by 113%.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.156 (relating to medical fee updates on and after January 1, 1995—skilled nursing facilities).

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

Payments to providers of home health care who file an HCFA Form 1728 (freestanding facilities) or an HCFA Form 2552 (hospital-based facilities), or any successor forms, shall be calculated as follows: the per visit limitation as determined by the Medicare Program multiplied by 113%. If the usual and customary charge per visit is lower than this calculation, then payment shall be limited to the usual and customary charge per visit. Payment at 113% of the Medicare limit shall represent payment for the entire service including all medical supplies and other items subject to cost reimbursement by the Medicare Program.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.157 (relating to medical fee updates on and after January 1, 1995—home health care providers).

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

(a) Payments to providers of outpatient and end-stage renal dialysis shall be calculated as follows: the Medicare composite rate, per treatment, shall be multiplied by 113%.

(b) Hospital outpatient ancillary services paid outside of the Medicare composite rate shall be reimbursed in accordance with § 127.119 (relating to payments for services using RCCs).

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.158 (relating to medical fee updates on and after January 1, 1995—outpatient and end-stage renal dialysis).

§ 127.125. ASCs.

Payments to providers of outpatient surgery in an ASC, shall be based on the ASC payment groups defined by HCFA, and shall include the Medicare list of covered services and related classifications in these groups. This payment amount shall be multiplied by 113%. For surgical procedures not included in the Medicare list of covered services, payments shall be based on 80% of the usual and customary charge.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); and 34 Pa. Code § 127.159 (relating to medical fee updates on and after January 1, 1995—ASCs).

§ 127.126. New providers.

(a) New providers who are receiving payments in accordance with § 127.103 or § 127.120 (relating to outpatient providers subject to the Medicare fee schedule—generally; and RCCs—comprehensive outpatient rehabilitation facilities (CORFs) and outpatient physical therapy centers) shall bill and receive payments beginning with the treatment of their first workers' compensation patient.

(b) New providers who are receiving payments in accordance with § 127.117 (relating to outpatient acute care providers, speciality hospitals and other cost-reimbursed providers not subject to the Medicare fee schedule) shall receive payments calculated as follows:

(1) Commencing with the date the provider begins treating its first patient until the completion and filing of the first Medicare cost report, payment shall be based on the aggregate RCC using the most recent Medicare interim rate notification.

(2) Within 30 days of the filing of the first cost report a new provider shall submit to the Bureau a copy of the detailed charge master in effect at the conclusion of the first cost report year and a copy of the filed cost report. Upon receipt of the filed cost report, payments shall be made in accordance with § 127.119 (relating to payments for services using RCCs), using the filed RCCs. The detailed charge master will be frozen in accordance with § 127.155 (relating to medical fee updates on and after January 1, 1995—outpatient acute care providers, specialty hospitals and other cost reimbursed providers).

(3) Upon receipt of the NPR, payments shall be made in accordance with § 127.119.

(c) A new provider shall submit a copy of the audited Medicare cost report and NPR to the Bureau within 30 days of receipt by the provider.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare).

§ 127.127. Mergers and acquisitions.

(a) When a merger, acquisition or change in ownership results in the elimination of the assets of a merged or acquired entity, and consolidation of the assets into the surviving entity, payments shall be determined by reference to the relevant cost reports and other relevant data of the surviving entity, except as noted in subsection (b).

(b) If services were provided at the merged or acquired provider that were not provided at the surviving provider (prior to merger or acquisition) and therefore were not reported as a cost center on its most recently audited Medicare cost report, the per diem rates and RCCs to be used for determining payment for these services shall be obtained from the most recently audited cost report of the merged or acquired provider.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare).

§ 127.128. Trauma centers and burn facilities—exemption from fee caps.

(a) Acute care provided in a trauma center or a burn facility is exempt from the medical fee caps, and shall be paid based on 100% of usual and customary charges if the following apply:

(1) The patient has an immediately life-threatening injury or urgent injury.

(2) Services are provided in an acute care facility that is one of the following:

(i) A level I or level II trauma center, accredited by the Pennsylvania Trauma Systems Foundation under the Emergency Medical Services Act (35 P. S. § § 6921—6938).

(ii) A burn facility which meets the service standards of the American Burn Association.

(b) Basic or advanced life support services, as defined and licensed under the Emergency Medical Services Act, provided in the transport of patients to trauma centers or burn facilities under subsection (a) are also exempt from the medical fee caps, and shall be paid based on 100% of usual and customary charges.

(c) If the patient is initially transported to the trauma center or burn facility in accordance with the American College of Surgeons' (ACS) triage guidelines, payment for transportation to the trauma center or burn facility, and payments for the full course of acute care services by all trauma center or burn facility personnel, and all individuals authorized to provide patient care in the trauma center or burn facility, shall be at the provider's usual and customary charge for the treatment and services rendered.

(d) The determination of whether a patient's initial and presenting condition meets the definition of a life-threatening or urgent injury shall be based upon the information available at the time of the initial assessment of the patient. A decision by ambulance personnel that an injury is life-threatening or urgent shall be presumptive of the reasonableness and necessity of the transport to a trauma center or burn facility, unless there is clear evidence of violation of the ACS triage guidelines.

(e) The exemptions in subsections (a) and (b) also apply when a patient has been transferred to a trauma center or burn facility pursuant to the ACS High-Risk Criteria for Consideration of Early Transfer.

(f) The exemptions also apply, and continue for the full course of treatment, when a patient is transferred from one trauma center or burn facility to another trauma center or burn facility.

(g) The medical fee cap exemptions may not continue to apply for payments for acute care treatment and services for life-threatening or urgent injuries following a transfer from a trauma center or burn facility to any other provider.

(h) Trauma centers and burn facilities shall provide the Bureau with evidence of their status including changes in status. An insurer may request evidence that an acute care facility's status as a trauma center or burn facility, was in effect on the dates services were rendered to an injured worker.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.160 (relating to medical fee updates on and after January 1, 1995—trauma centers and burn facilities).

§ 127.129. Out-of-State medical treatment.

(a) When injured employes are treated outside of this Commonwealth by providers who are licensed by the Commonwealth to provide health care services, the applicable medical fee cap shall be as follows:

(1) If the provider is both licensed by and has a place of business within this Commonwealth, the medical fees shall be capped based on the Medicare reimbursement rate applicable under the Medicare Program for services rendered at the provider's primary place of business in this Commonwealth, subject to § 127.152 (relating to medical fee updates on and after January 1, 1995—generally).

(2) If the provider is licensed by the Commonwealth to provide health care services but does not have a place of business within this Commonwealth, medical fees shall be capped based on the Medicare reimbursement rate applicable in Harrisburg, Pennsylvania, under the Medicare Program for the services rendered subject to § 127.152.

(b) When injured employes are treated outside of this Commonwealth by providers who are not licensed by the Commonwealth to provide health care services, medical fees shall be capped based on the Medicare reimbursement rate applicable in Harrisburg, Pennsylvania, under the Medicare Program for the services rendered subject to § 127.152.

§ 127.130. Special reports.

(a) Payments shall be made for special reports (CPT code 99080) only if these reports are specifically requested by the insurer. Office notes and other documentation which are necessary to support provider codes billed may not be considered special reports.

(b) Payments for special reports shall be at 80% of the provider's usual and customary charge.

(c) The Bureau-prescribed report required by § 127.203 (relating to medical bills—submission of medical reports) may not be considered a special report that is chargeable under this section.

§ 127.131. Payments for prescription drugs and pharmaceuticals—generally.

(a) Payments for prescription drugs and professional pharmaceutical services shall be limited to 110% of the average wholesale price (AWP) of the product.

(b) Pharmacists and insurers may reach agreements on which Nationally recognized schedule shall be used to define the AWP of prescription drugs. The Bureau in resolving payment disputes, may use any of the Nationally recognized schedules to determine the AWP of prescription drugs. The Bureau will provide information by an annual notice in the *Pennsylvania Bulletin* as to which of the Nationally recognized schedules it is using to determine the AWP of prescription drugs.

(c) Pharmacists may not bill, or otherwise hold the employe liable, for the difference between the actual charge for the prescription drugs and pharmaceutical services and 110% of the AWP of the product.

§ 127.132. Payments for prescription drugs and pharmaceuticals—direct payment.

(a) Insurers may enter into agreements with pharmacists authorizing pharmacists to bill the cost of prescription drugs directly to the insurer.

(b) When agreements are reached under subsection (a), insurers shall promptly notify injured employes of the names and locations of pharmacists who have agreed to directly bill and accept payment from the insurer for prescription drugs. However, insurers may not require employes to fill prescriptions at the designated pharmacies.

§ 127.133. Payments for prescription drugs and pharmaceuticals—effect of denial of coverage by insurers.

If an injured employe pays more than 110% of the average wholesale price of a prescription drug because the insurer initially does not accept liability for the claim under the act, or denies liability to pay for the prescription, the insurer shall reimburse the injured employe for the actual cost of the prescription drugs, once liability has been admitted or determined.

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

A pharmacy or pharmacist owned or employed by a health care provider, which is recognized and reimbursed as an ancillary service by Medicare, and which dispenses prescription drugs to individuals during the course of treatment in the provider's facility, shall receive payment under the applicable Medicare reimbursement mechanism multiplied by 113%.

§ 127.135. Payments for prescription drugs and pharmaceuticals—drugs dispensed at a physician's office.

(a) When a prescription is filled at a physician's office, payment for the prescription drug shall be limited to 110% of the average wholesale price of the product.

(b) Physicians may not bill, or otherwise hold the employe liable, for the difference between the actual charge for the prescription drug and 110% of the AWP of the product.

MEDICAL FEE UPDATES

§ 127.151. Medical fee updates prior to January 1, 1995—generally.

(a) Changes in Medicare reimbursement rates prior to January 1, 1995, shall be reflected in calculations of payments to providers under the act.

(b) The effective date for these rate changes under the Medicare Program shall also be the effective date for the fee changes under the act. The new rates shall apply to all treatment and services provided on and after the effective date of the rate change.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); and 34 Pa. Code § 127.103 (relating to outpatient providers subject to the Medicare fee schedule—generally).

§ 127.152. Medical fee updates on and after January 1, 1995—generally.

(a) Changes in Medicare reimbursement rates on and after January 1, 1995, may not be included in calculations of payments to providers under Act 44.

(b) Medical fee updates on and after January 1, 1995, shall be calculated based on the percentage changes in the Statewide average weekly wage, as published annually by the Department in the *Pennsylvania Bulletin*. These updates shall be effective on January 1 of each year, and they shall be cumulative.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.103 (relating to outpatient providers subject to the Medicare fee schedule—generally); and 34 Pa. Code § 127.129 (relating to out-of-State medical treatment).

§ 127.153. Medical fee updates on and after January 1, 1995—outpatient providers, services and supplies subject to the Medicare fee schedule.

(a) On and after January 1, 1995, outpatient providers whose payments under the act are based on the Medicare fee schedule under § § 127.103—127.108 shall be paid as follows: the amount of payment authorized shall be frozen on December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.

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

(c) On and after January 1, 1995, payment rates under the act for new HCPCS codes will be based on the rates allowed in the Medicare fee schedule on the effective date of the new codes. These payment rates shall be frozen immediately, and thereafter updated annually by the percentage change in the Statewide average weekly wage.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); and 34 Pa. Code § 127.103 (relating to outpatient providers subject to the Medicare fee schedule—generally).

§ 127.154. Medical fee updates on and after January 1, 1995—inpatient acute care providers subject to DRGs plus add-on payments.

(a) On and after January 1, 1995, inpatient acute care providers, whose payments under the act are based on DRGs plus add-ons under § § 127.110—127.116 shall be paid as follows: the amount of payment authorized and based on the DRG shall be frozen on December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.

(b) The DRG grouper in effect for Medicare DRG payments as of December 31, 1994, shall remain in effect and be frozen for purposes of determining payments under the act. Additions, deletions or modifications to the ICD-9 codes used to determine the DRG shall be mapped to the appropriate DRG within the frozen grouper.

(c) The relative values of DRGs in effect on December 31, 1994, shall be frozen for purposes of calculating payments under the act. The introduction of modified or new DRGs, on and after January 1, 1995, may not be utilized for purposes of calculating payments under the act.

(d) On and after January 1, 1995, add-on payments based on capital-related costs as set forth in § 127.112 (relating to inpatient acute care providers—capital-related costs) shall be frozen at the rates in effect on December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.

(e) On and after January 1, 1995, add-on payments based on medical education costs as set forth in § 127.113 (relating to inpatient acute care providers—medical education costs) shall be frozen based on the calculations made using the Medicare cost report and Medicare interim rate notification in effect on December 31, 1994. These frozen rates shall be applied to the updated DRG rates in subsection (a).

(1) Hospitals which lose the right to receive add-on payments based on medical education costs under the Medicare Program on and after January 1, 1995, shall also lose their right to receive these payments under the act as set forth in § 127.113. Commencing with services rendered on or after January 1 of the year succeeding the change in status, the add-on payment that has been computed and included in the Medicare fee cap as frozen on December 31, 1994, shall be eliminated from the calculation of the reimbursement.

(2) Hospitals which gain the right to receive add-on payments based on medical education costs under the Medicare Program on and after January 1, 1995, shall receive payments based on the rates calculated in § 127.113(c). These payments shall be frozen immediately, and thereafter shall be applied to the updated DRG rates in subsection (a).

(f) On and after January 1, 1995, add-on payments based on cost outliers as set forth in § 127.114 (relating to inpatient acute care providers—outliers) shall continue to float with changes made pursuant to the Medicare Program, using the most recently audited cost reports to calculate the additional payment. These payments may not receive fee updates based on changes in the Statewide average weekly wage.

(g) On and after January 1, 1995, add-on payments based on day outliers as set forth in § 127.114 shall be frozen based on the arithmetic and geometric mean length of stay in effect for discharges on December 31, 1994. These frozen rates shall be applied to the updated DRG rates in subsection (a).

(h) On and after January 1, 1995, add-on payments based on the designation under the Medicare Program as a disproportionate share hospital, shall be frozen based on the designation and calculation in effect on December 31, 1994. These frozen rates shall be applied to the updated DRG rates in subsection (a).

(i) On and after January 1, 1995, payments based on designations under the Medicare Program as a Medicare-dependent small rural hospital, sole-community hospital and Medicare-geographically reclassified hospital shall be frozen based on the designations and calculations in effect on December 31, 1994. These rates shall be updated annually by the percentage change in the Statewide average weekly wage.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare).

§ 127.155. Medical fee updates on and after January 1, 1995—outpatient acute care providers, specialty hospitals and other cost-reimbursed providers.

(a) As of January 1, 1995, providers identified in § 127.117 (relating to outpatient acute care providers, specialty hospitals and other cost-reimbursed providers not subject to the Medicare fee schedule) shall be paid as follows: as of December 31, 1994, the provider's actual charge by procedure as determined from the detailed charge master, shall be multiplied by the ratio of cost-to-charges, based on the most recently audited Medicare cost report. Except as noted in subsection (b), this amount shall be frozen for purposes of calculating payments under the act and updated annually by the percentage change in the Statewide average weekly wage.

(b) Subsection (a) does not apply in situations where the charge master does not contain unique charges for each item of pharmacy, but instead actual charges are based on algorithms or other mathematical calculations to compute the charge. For purposes of effectuating the freeze, the providers' RCC for pharmacy (drug charges to patients) shall be frozen based on the last audited Medicare cost report as of December 31, 1994. On and after January 1, 1995, the providers' actual charges shall be multiplied by the frozen RCC and then by 113% to determine reimbursements. These payments may not receive fee updates based on changes in the Statewide average weekly wage.

(c) For purposes of effectuating the freeze in reimbursements as provided in subsection (a), the Bureau will calculate the appropriate fee caps for cost-reimbursed providers who are identified in § 127.117. In order to accomplish this task, the Bureau will utilize information obtained from a complete copy of the provider's detailed charge master by procedure/service codes, HCPCS codes and by applicable Medicare revenue code with rates effective as of September 1, 1994, and RCCs from the most recently audited Medicare cost report in effect as of December 31, 1994.

(1) The charge information obtained for purposes of subsection (c) calculations, will remain in the possession of the Bureau. Unless the Bureau obtains the written permission of the provider, the charge information will not be released to anyone other than an authorized representative of the provider.

(2) The Bureau will provide the calculated fees to insurers.

(d) Cost-reimbursed providers adding new services requiring the addition of new procedure codes within previously reported Medicare revenue codes and frozen RCCs shall receive payment based on the charge associated with the new code multiplied by the frozen RCC.

(e) Cost-reimbursed providers adding new services requiring the addition of new procedure codes outside of the previously reported Medicare revenue codes and frozen RCC, shall receive payment as follows:

(1) Prior to the completion of the audited cost report which includes the new services, payment shall be based on 80% of the provider's usual and customary charge.

(2) Upon completion of the first audited cost report which includes the new services, payment shall be based on the charge associated with the new code multiplied by the audited RCC including those charges. Payment rates shall be frozen immediately and updated annually by the percentage change in the Statewide average weekly wage.

(f) On and after January 1, 1995, add-on payments based on medical education costs as set forth in § 127.121 (relating to cost-reimbursed providers—medical education costs) shall be frozen based on the calculations made using the Medicare Cost Report. These rates shall be updated annually by the percentage change in the Statewide average weekly wage.

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

(2) Cost-reimbursed providers that gain the right to receive add-on payments based on medical education costs under the Medicare Program on and after January 1, 1995, shall receive payments based on the rates calculated in § 127.121. These rates shall be frozen immediately and shall be updated annually by the percentage change in the Statewide average weekly wage.

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

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

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

Cross References

This section cited in 34 Pa. Code § 126.1 (relating to medical fee updates); 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.126 (relating to providers); 34 Pa. Code § 127.201 (relating to medical bills—standard forms); 34 Pa. Code § 127.253 (relating to application for fee review—documents required generally).

§ 127.156. Medical fee updates on and after January 1, 1995—skilled nursing facilities.

On and after January 1, 1995, payments to skilled nursing facilities shall be as follows: the amount of the payment set forth in § 127.122 (relating to skilled nursing facilities) shall be frozen on December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare).

§ 127.157. Medical fee updates on and after January 1, 1995—home health care providers.

On and after January 1, 1995, payments to home health care providers shall be as follows: the amount of the payment set forth in § 127.123 (relating to hospital-based and freestanding home health care providers) shall be frozen on December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare).

§ 127.158. Medical fee updates on and after January 1, 1995—outpatient and end-stage renal dialysis.

On and after January 1, 1995, payments to providers of outpatient and end-stage renal dialysis shall be as follows: the amount of the payment set forth in § 127.124 (relating to outpatient and end-stage renal dialysis payments) shall be frozen on December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare).

§ 127.159. Medical fee updates on and after January 1, 1995—ASCs.

On and after January 1, 1995, payments to providers of outpatient surgery in ASCs shall be as follows: the amount of the payment in § 127.125 (relating to ASCs) shall be frozen on December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare).

§ 127.160. Medical fee updates on and after January 1, 1995—trauma centers and burn facilities.

Trauma centers and burn facilities shall continue to receive their usual and customary charges on and after January 1, 1995, in accordance with § 127.128 (relating to trauma centers and burn facilities—exemption from fee caps).

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare).

§ 127.161. Medical fee updates on and after January 1, 1995—prescription drugs and pharmaceuticals.

Payments for prescription drugs and professional pharmaceutical services shall continue to be limited to 110% of the average wholesale price on and after January 1, 1995.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare).

§ 127.162. Medical fee updates on and after January 1, 1995—new allowances adopted by Commissioner.

On and after January 1, 1995, if the Commissioner adopts new allowances for services provided under the act, those new allowances will be frozen immediately, and thereafter updated annually by the percentage change in the Statewide average weekly wage.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare).

BILLING TRANSACTIONS

§ 127.201. Medical bills—standard forms.

(a) Requests for payment of medical bills shall be made either on the HCFA Form 1500 or the UB92 Form (HCFA Form 1450), or any successor forms, required by HCFA for submission of Medicare claims. If HCFA accepts a form for submission of Medicare claims by a certain provider, that form shall be acceptable for billing under the act.

(b) Cost-based providers shall submit a detailed bill including the service codes consistent with the service codes submitted to the Bureau on the detailed charge master in accordance with § 127.155(b) (relating to medical fee updates on and after January 1, 1995—outpatient acute care providers, specialty hospitals and other cost-reimbursed providers), or consistent with new service codes added under § 127.155(d) and (e).

Cross References

This section cited in § 127.202 (relating to medical bills—use of alternative forms).

§ 127.202. Medical bills—use of alternative forms.

(a) Until a provider submits bills on one of the forms specified in § 127.201 (relating to medical bills—standard forms) insurers are not required to pay for the treatment billed.

(b) Insurers may not require providers to use any form of medical bill other than the forms required by § 127.201.

Notes of Decisions

Forms

The Commonwealth Court remanded to the Workers' Compensation Appeal Board with instructions that the Board remand to the Workers' Compensation Judge to give the health care provider an opportunity to submit his medical bills on the forms mandated by Act 44, where the regulations reinforce the obligation of the health care provider to submit his bill on the proper form before payment will be made and, moreover, the regulations also require that medical reports be submitted before payment is due. *AT&T v. Workers' Compensation Appeal Board (Dinapoli)*, 728 A.2d 381 (Pa. Cmwlth. 1999); appeal denied 829 A.2d 311 (Pa. 2003).

§ 127.203. Medical bills—submission of medical reports.

(a) Providers who treat injured employees are required to submit periodic medical reports to the employer, commencing 10 days after treatment begins and at least once a month thereafter as long as treatment continues. If the employer is covered by an insurer, the provider shall submit the report to the insurer.

(b) Medical reports are not required to be submitted in months during which treatment has not been rendered.

(c) The medical reports required by subsection (a) shall be submitted on a form prescribed by the Bureau for that purpose. The form shall require the provider to supply, when pertinent, information on the claimant's history, the diagnosis, a description of the treatment and services rendered, the physical findings and the prognosis, including whether or not there has been recovery enabling the claimant to return to pre-injury work without limitations. Providers shall supply only the information applicable to the treatment or services rendered.

(d) If a provider does not submit the required medical reports on the prescribed form, the insurer is not obligated to pay for the treatment covered by the report until the required report is received by the insurer.

Notes of Decisions

Medical Reports

An employeer is only responsible to pay reasonable and necessary medical bills when submitted in the manner prescribed by the act and regulations, which includes the requirement that provider file periodic reports with the employer on an approved form. *Budd Co. v. W.C.A.B. (Kan)*, 858 A.2d 170 (Pa. Cmwlth. 2004).

The Commonwealth Court remanded to the Workers' Compensation Appeal Board with instructions that the Board remand to the Workers' Compensation Judge to give the health care provider an opportunity to submit his medical bills on the forms mandated by Act 44, where the regulations reinforce the obligation of the provider to submit his bill on the proper form before payment will be made and, moreover, the regulations require that medical reports be submitted before payment is due. *AT&T v. Workers' Compensation Appeal Board (Dinapoli)*, 728 A.2d 381 (Pa. Cmwlth. 1999); appeal denied 829 A.2d 311 (Pa. 2003).

Cross References

This section cited in 34 Pa. Code § 127.130 (relating to special reports).

§ 127.204. Fragmenting or unbundling of charges by providers.

A provider may not fragment or unbundle charges except as consistent with Medicare.

Cross References

This section cited in 34 Pa. Code § 127.109 (relating to supplies and services not covered by fee schedule).

§ 127.205. Calculation of amount of payment due to providers.

Bills submitted by providers for payment shall state the provider's actual charges for the treatment rendered. A provider's statement of actual charges will not be construed to be an unlawful request or requirement for payment in excess of the medical fee caps. The insurer to whom the bill is submitted shall calculate the proper amount of payment for the treatment rendered.

Notes of Decisions

Calculation

The Workers' Compensation Judge erred in awarding medical expenses in the amount of $40,000 without reducing them to the applicable fee caps even though this regulation did not become effective until November 11, 1995, after the health care provider had submitted his bills, where the court was remanding the case so that the provider could submit his bills on the required forms; because this regulation is procedural, as it does not alter any substantive rights, the court instructed the employer and its insurance carrier to calculate the proper amount of payment for the treatment rendered. *AT&T v. Workers' Compensation Appeal Board (Dinapoli)*, 728 A.2d 381 (Pa. Cmwlth. 1999); appeal denied 829 A.2d 311 (Pa. 2003).

Retroactive Application

The Workers' Compensation Appeal Board erred in relying upon this regulation in determining that the insurer must calculate the amounts payable under the medical fee caps for the treatment at issue, where this regulation did not become effective until November 11, 1995, after the treatment which ended in December 1994. *Acme Markets, Inc. v. Workers' Compensation Appeal Board*, 725 A.2d 863 (Pa. Cmwlth. 1999); appeal denied 743 A.2d 923 (Pa. 1999).

§ 127.206. Payment of medical bills—request for additionaldocumentation.

Insurers may request additional documentation to support medical bills submitted for payment by providers, as long as the additional documentation is relevant to the treatment for which payment is sought.

§ 127.207. Downcoding by insurers.

(a) Changes to a provider's codes by an insurer may be made if the following conditions are met:

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

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

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

(4) The changes are consistent with Medicare guidelines, the act and this subchapter.

(b) For purposes of subsection (a)(1), the provider shall be given 10 days to respond to the notice of the proposed changes, and the insurer must have written evidence of the date notice was sent to the provider.

(c) Whenever changes to a provider's billing codes are made, the insurer shall state the reasons why the provider's original codes were changed in the explanation of benefits required by § 127.209 (relating to explanation of benefits paid).

(d) If an insurer changes a provider's codes without strict compliance with subsections (a)—(c), the Bureau will resolve an application for fee review filed under § 127.252 (relating to application for fee review—filing and service) in favor of the provider under § 127.254 (relating to downcoding disputes).

Notes of Decisions

Billing Codes

The insurer's argument that it can summarily deny any application for medical fee reimbursement as incomplete if the application contains a billing code that the insurer believes should be different than the one used, and when that occurs, it is not required to contact the provider or provide a reason for denial, was disingenuous, where its assertion was contrary to the plain language of this regulation and the only reason it gave for denying payment was that the therapy billed for was unproven. *Philadelphia v. Medical Fee Review Hearing Office*, 737 A.2d 356 (Pa. Cmwlth. 1999).

Cross References

This section cited in 34 Pa. Code § 127.254 (relating to downcoding disputes).

§ 127.208. Time for payment of medical bills.

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

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

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

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

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

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

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

Source

The provisions of this § 127.208 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial pages (203479) to (203480).

Notes of Decisions

Payment for Medical Treatment

Once it is determined that an employer is liable for an injury under the Workers' Compensation Act, the employer is required to pay claimant's medical bills within 30 days of receipt. *Westinghouse Electric v. W.C.A.B. (Weaver)*, 823 A.2d 209, 218 (Pa.Cmwlth 2003); appeal denied 864 A.2d 531 (Pa. 2004).

Suspension of Payment

The Workers' Compensation Judge did not err by failing to order the employer to pay the chiropractor's bills up to the date of his decision, where this regulation permits a suspension of an employer's obligation to continue paying medical bills during the utilization review process. *Musko v. Workers' Compensation Appeal Board (Calgon Carbon Corp.)*, 729 A.2d 657 (Pa. Cmwlth. 1999).

Cross References

This section cited in 34 Pa. Code § 127.255 (relating to premature applications for fee review); and 34 Pa. Code § 127.479 (relating to determination against insurer—payment of medical bills).

§ 127.209. Explanation of benefits paid.

(a) Insurers shall supply a written explanation of benefits (EOB) to the provider, describing the calculation of payment of medical bills submitted by the provider. If payment is based on changes to a provider's codes, the EOB shall state the reasons for changing the original codes. If payment of a bill is denied entirely, insurers shall provide a written explanation for the denial.

(b) All EOBs shall contain the following notice: ''Health care providers are prohibited from billing for, or otherwise attempting to recover from the employe, the difference between the provider's charge and the amount paid on this bill.''

Cross References

This section cited in 34 Pa. Code § 127.207 (relating to downcoding by insurers); 34 Pa. Code § 127.255 (relating to premature applications for fee review); 34 Pa. Code § 127.302 (relating to resolution of self-referral disputes by Bureau).

§ 127.210. Interest on untimely payments.

(a) If an insurer fails to pay the entire bill within 30 days of receipt of the required bills and medical reports, interest shall accrue on the due and unpaid balance at 10% per annum under section 406.1(a) of the act (77 P. S. § 717.1).

(b) If an insurer fails to pay any portion of a bill, interest shall accrue at 10% per annum on the unpaid balance.

(c) Interest shall accrue on unpaid medical bills even if an insurer initially denies liability for the bills if liability is later admitted or determined.

(d) Interest shall accrue on unpaid medical bills even if an insurer has filed a request for UR under Subchapter C (relating to medical treatment review) if a later determination is made that the insurer was liable for paying the bills.

§ 127.211. Balance billing prohibited.

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

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

Notes of Decisions

A medical provider is prohibited from collecting from the employee claimant the difference between the amount paid by the employer or Workers' Compensation carrier and the provider's charge. *Nickel v. Workers' Compensation Appeal Board* (*Agway Agronomy*), 959 A.2d 498, 504 (Pa. Cmwlth. 2008).

A claimant is never liable for the difference between that charged by the health care provider and that paid by the employer. *Jaquay v. Workers' Compensation Appeal Board*, 717 A.2d 1075, 1078 (Pa. Cmwlth. 1998).

REVIEW OF MEDICAL FEE DISPUTES

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

A provider who has submitted the required bills and reports to an insurer and who disputes the amount or timeliness of the payment made by an insurer, shall have standing to seek review of the fee dispute by the Bureau.

Notes of Decision

A fee review officer has no authority to decide the issue of liability in a fee review proceeding. The issue for a fee review officer is the "amount and timeliness of the payment made by an insurer." *Nickel v. Workers' Comp. Appeal Bd.* (*Agway Agronomy*), 959 A.2d 498, 503 (Pa. Cmwlth. 2008).

Cross References

This section cited in 34 Pa. Code § 127.302 (relating to resolution of self-referral disputes by Bureau).

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

(a) Providers seeking review of fee disputes shall file the original and one copy of a form prescribed by the Bureau as an application for fee review. The application shall be filed no more than 30 days following notification of a disputed treatment or 90 days following the original billing

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

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

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

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

Source

The provisions of this § 127.252 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial pages (203481) to (203482).

Notes of Decisions

Burden

Although insurer bears the burden of proving that it properly reimbursed provider, the provider must first show that it filed a timely application for fee review. The provider has the burden of proving the existence of a dispute as to liability. *Thomas Jefferson University Hospital v. Bureau of Workers' Compensation Medical Fee Review Hearing Office*, 794 A.2d 933, 935 (Pa. Cmwlth. 2002).

Time

Where there is a dispute as to liability, but the provider has actual knowledge of a decision regarding liability, the provider must file its application within 30 days of notification of that decision, or 90 days from the original billing date. *Thomas Jefferson University Hospital v. Bureau of Workers' Compensation Medical Fee Review Hearing Office*, 794 A.2d 933, 934 (Pa. Cmwlth. 2002).

Time limits for medical provider to file application for review of medical fee disputes with workers' compensation insurer is 90 days following the original billing date of treatment on the UB92 form, not the date the bill was sent by provider to insurer; hospital's fee review application was untimely and subject to denial since it was submitted 102 days after the original billing date. *Nationwide Mut. Fire Ins. Co. v. Bureau of Workers' Comp. Fee Review Hearing Office*, 981 A.2d 366 (Pa. Cmwlth. 2009).

Time for Review

Where the original Application for Fee Review was denied because of the failure to submit the forms required under § 127.202, the time for submission of a fee review runs from the insurer's denial of a later Application by the provider which complies with the form requirements. *Harburg Medical Sales Co. v. Bureau of Workers' Compensation*, 784 A.2d 866, 870 (Pa. Cmwlth. 2001).

Cross References

This section cited in 34 Pa. Code § 127.207 (relating to downcoding by insurers).

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

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

(1) The applicable Medicare billing form.

(2) The required medical report form, together with office notes and documentation supporting the procedures performed or services rendered.

(3) The explanation of benefits, if available.

(b) Providers reimbursed under the Medicare Part A Program and providers reimbursed by Medicare based on HCFA Forms 2552, 2540, 2088 or 1728, or successor forms, shall submit the following documents with the application for fee review:

(1) The applicable Medicare billing form.

(2) The most recent Medicare interim rate notification.

(3) The most recent Notice of Program Reimbursement.

(4) The most recently audited Medicare cost report.

(5) The required medical report form, together with documentation supporting the procedures performed or services rendered.

(6) The explanation of benefits, if available.

(c) For treatment rendered on and after January 1, 1995, the items specified in subsections (b)(2)—(4) shall be submitted if the requirements of § 127.155 (relating to medical fee updates on and after January 1, 1995—outpatient acute care providers, specialty hospitals and other cost-reimbursed providers) have been met.

Cross References

This section cited in 34 Pa. Code § 127.252 (relating to application for fee review—filing and service).

§ 127.254. Downcoding disputes.

(a) When changes in procedure codes are the basis for a fee dispute, the Bureau will give the provider and the insurer the opportunity to produce copies of written communications concerning the changes in procedure codes.

(b) If an insurer has not complied with § 127.207 (relating to downcoding by insurers) the Bureau will resolve downcoding disputes in favor of the provider.

Notes of Decisions

Notice

The hearing officer did not err in resolving the fee review dispute in favor of the provider, where the insurer notified the provider that it was not paying because of the unproven nature of the treatment and shifted to the coding issue only after the review was underway and where insurer fails

to strictly comply with notice requirements. *Philadelphia v. Medical Fee Review Hearing Office*, 737 A.2d 356 (Pa. Cmwlth. 1999).

Cross References

This section cited in 34 Pa. Code § 127.207 (relating to downcoding by insurers).

§ 127.255. Premature applications for fee review.

The Bureau will return applications for fee review prematurely filed by providers when one of the following exists:

(1) The insurer denies liability for the alleged work injury.

(2) The insurer has filed a request for utilization review of the treatment under Subchapter C (relating to medical treatment review).

(3) The 30-day period allowed for payment has not yet elapsed, as computed under § 127.208 (relating to time for payment of medical bills).

Notes of Decisions

Premature Fee Review Request

Department of Labor and Industry could not consider medical provider's fee review application for services provided to workers' compensation claimant after insurer denied liability for the claim; determination of whether insurer is liable for an injury requires the exercise of legal judgment and requires the Department to evaluate the Notice of Compensation Payable that insurer issued, insurer's denial, and any other relevant documentation and evidence. *Crozer Chester Medical Center v. Dep't. of Labor & Industry*, 955 A.2d 1037, 1042 (Pa. Cmwlth. 2008).

Provider who supplied workers' compensation claimant with orthopedic mattress, foundation, and frame pursuant to doctor's order, failed to establish it mailed bill for equipment to insurer on November 18; instead, the hearing officer credited insurer's evidence that it did not receive bill until December 28, therefore insurer's utilization review request received by Workers' Compensation Bureau on January 12 of the following year was timely since it was within 30 days of receipt of bill as required by law and insurer's obligation to pay had not yet been established, providers' fee review application was properly denied and dismissed. *Harrisburg Medical Sales Co. v. Bureau of Workers' Compensation (Employers' Mutual Casualty Co.)*, 911 A.2d 214 (Pa. Cmwlth. 2006).

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

When a provider has filed all the documentation required and is entitled to a decision on the merits of the application for fee review, the Bureau will render an administrative decision within 30 days of receipt of all required documentation from the provider. The Bureau will, prior to rendering the administrative decision, investigate the matter and contact the insurer to obtain its response to the application for fee review.

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

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

(b) The party contesting the administrative decision shall file an original and seven copies of a written request for a hearing with the Bureau within 30 days of the date of the administrative decision on the fee review. The hearing request shall be mailed to the Bureau at the address listed on the administrative decision.

(c) A copy of the request for a hearing shall be served upon the prevailing party in the fee dispute. A proof of service, indicating the person served, the date of service and the form of service, shall be provided to the Bureau at the time the request for hearing is filed.

(d) An untimely request for a hearing may be dismissed without further action by the Bureau.

(e) Filing of a request for a hearing shall act as a supersedeas of the administrative decision on the fee review.

§ 127.258. Bureau as intervenor.

The Bureau may, as an intervenor in the fee review matter, defend the Bureau's initial administrative decision on the fee review.

§ 127.259. Fee review hearing.

(a) The Bureau will assign the request for a hearing to a hearing officer who will schedule a de novo proceeding. All parties will receive reasonable notice of the hearing date, time and place.

(b) The hearing will be conducted in a manner to provide all parties the opportunity to be heard. The hearing officer will not be bound by strict rules of evidence. All relevant evidence of reasonably probative value may be received into evidence. Reasonable examination and cross-examination of witnesses will be permitted.

(c) The parties may be represented by legal counsel, but legal representation at the hearing is not required.

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

(e) All parties will be provided the opportunity to submit briefs addressing issues raised.

(f) The insurer shall have the burden of proving by a preponderance of the evidence that it properly reimbursed the provider.

Cross References

This section cited in 34 Pa. Code § 127.302 (relating to resolution of self-referral disputes by Bureau).

§ 127.260. Fee review adjudications.

(a) The hearing officer will issue a written decision and order within 90 days following the close of the record. The decision will include all relevant findings and conclusions, and state the rationale for the fee review adjudication.

(b) The fee review adjudication will include a notification to all parties of appeal rights to Commonwealth Court.

(c) The fee review adjudication will be served upon all parties, intervenors and counsel of record.

Cross References

This section cited in 34 Pa. Code § 127.261 (relating to further appeal rights); 34 Pa. Code § 127.302 (relating to resolution of self-referral disputes by Bureau).

§ 127.261. Further appeal rights.

Any party aggrieved by a fee review adjudication rendered pursuant to § 127.260 (relating to fee review adjudications) may file an appeal to Commonwealth Court within 30 days from mailing of the decision.

SELF-REFERRALS

§ 127.301. Referral standards.

(a) Under section 306(f.1)(3)(iii) of the act (77 P. S. § 531(3)(iii)), a provider may not refer a person for certain treatment and services if the provider has a financial interest with the person or in the entity that receives the referral. A provider may not enter into an arrangement or scheme, such as a cross-referral arrangement, which the provider knows, or should know, has a principal purpose of assuring referrals by the provider to a particular entity which, if the provider directly made referrals to the entity, would be in violation of the act.

(b) No claim for payment may be presented by a person, provider or entity for a service furnished under a referral prohibited under subsection (a).

(c) Referrals permitted under all present and future Safe Harbor regulations promulgated under the Medicare and Medicaid Patient and Program Protection Act at 42 U.S.C.A. § 1320a-7b(1) and (2), published at 42 CFR 1001.952 (relating to exceptions), and all present and future exceptions to the Stark amendments to the Medicare Act at 42 U.S.C.A. § 1395nn, and all present and future regulations promulgated thereunder are not prohibited referrals involving financial interest. An insurer may not deny payment to a health care provider involved in such transaction or referral.

(d) For purposes of section 306(f.1)(3)(iii) of the act, a CCO will be considered a single health care provider.

§ 127.302. Resolution of self-referral disputes by Bureau.

(a) If an insurer determines that a bill has been submitted for treatment rendered in violation of the referral standards, the insurer is not liable to pay the bill. Within 30 days of receipt of the provider's bill and medical report, the insurer shall supply a written explanation of benefits, under § 127.209 (relating to explanation of benefits paid), stating the basis for believing that the self-referral provision has been violated.

(b) A provider who has been denied payment of a bill under subsection (a) may file an application for fee review with the Bureau under § 127.251 (relating to medical fee disputes—review by the Bureau) An application for fee review filed under this subsection will be assigned to a hearing officer for a hearing and adjudication in accordance with the procedures set forth in § § 127.259 and 127.260 (relating to fee review hearing; and fee review adjudications).

(c) The insurer shall have the burden of proving by a preponderance of the evidence that a violation of the self-referral provisions has occurred.

Subchapter C. MEDICAL TREATMENT REVIEW

UR—GENERAL REQUIREMENTS

Sec.

UR—INITIAL REQUEST

UR—PETITION FOR REVIEW

PEER REVIEW

AUTHORIZATION OF UROs AND PROs

Cross References

This subchapter cited in 34 Pa. Code § 127.208 (relating to time for payment of medical bills); 34 Pa. Code § 127.210 (relating to interest on untimely payments); 34 Pa. Code § 127.211 (relating to balance billing prohibited); 34 Pa. Code § 127.252 (relating to application for fee review—filing and service); 34 Pa. Code § 127.255 (relating to premature applications for fee review); and 34 Pa. Code § 127.755 (relating to required notice of employe rights and duties).

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.

Source

The provisions of this § 127.401 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial pages (203488) to (203489).

Notes of Decisions

Utilization Review Process

Utilization review process is exclusive way to challenge the reasonableness and necessity of medical bills of a workers' compensation claimant; neither a Workers' Compensation Judge nor the Workers' Compensation Appeal Board has jurisdiction to determine the reasonableness of medical treatment unless and until a report is issued and the Utilization Review Organization issues a

determination. *County of Allegheny (John J. Kane Ctr.—Ross) v. Workers' Compensation Appeal Board (Geisler)*, 875 A.2d 1222, 1226 (Pa. Cmwlth. 2005).

Cross References

This section cited in 34 Pa. Code § 127.404 (relating to prospective, concurrent and retrospective review).

§ 127.402. Treatment subject to review.

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

§ 127.403. Assignment of cases to UROs by the Bureau.

The Bureau will randomly assign requests for UR to authorized UROs. An insurer's obligation to pay medical bills within 30 days of receipt shall be tolled only when a proper request for UR has been filed with the Bureau in accordance with this subchapter.

§ 127.404. Prospective, concurrent and retrospective review.

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

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

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

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

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

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

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

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

Source

The provisions of this § 127.404 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial pages (203489) to (20390).

Notes of Decisions

Error on Request Form

The fact that the employer erroneously checked the ''medical only'' box on its review request would not void its otherwise permissible utilization review request. *Carter v. Workers' Compensation Appeal Board (Hertz Corp.)*, 790 A.2d 1105, 1108 (Pa. Cmwlth. 2002).

Interpretation

The phrase ''in which to request'' in subsection (b) is synonymous with ''filing an application'' as used in section 306(f.1)(5) of the Workers' Compensation Act (77 P. S. § 531(5)). *Chik-Fil-A v. Workers' Compensation Appeal Board (Mollick)*, 792 A.2d 678, 686 (Pa. Cmwlth. 2002).

Jurisdiction

Because liability had not been established to commence the running of the 30-day period for filing a utilization review request, the workers' compensation judge was without jurisdiction to determine the reasonableness and necessity of the claimant's medical expenses. That determination was therefore vacated. *Chik-Fil-A v. Workers' Compensation Appeal Board (Mollick)*, 792 A.2d 678, 687 (Pa. Cmwlth. 2002).

Request During Pendency of Claim

An employer is not precluded from filing a request for retrospective utilization review during the pendency of the claimant's claim petition. *Carter v. Workers' Compensation Appeal Board (Hertz Corp.),* 790 A.2d 1105, 1108 (Pa. Cmwlth. 2002).

Termination Petition

The tolling of the 30-day period for challenging medical bills does not apply to termination petitions. *Ryndycz v. W.C.A.B. (White Engineering*), 936 A.2d 146, 151 (Pa. Cmwlth. 2007).

Time

Because a determination of liability was pending, the employer had not waived its right to challenge the reasonableness or necessity of claimant's medical bills by its failure to request retrospective utilization review. *Chik-Fil-A v. Workers' Compensation Appeal Board (Mollick)*, 792 A.2d 678, 686 (Pa. Cmwlth. 2002).

§ 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.

Source

The provisions of this § 127.405 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial page (203490).

Notes of Decisions

UR Decision Not Moot

Decision arising from employer's utilization review request which was filed prior to claimant's claim petition was not rendered moot because a WCJ never has original jurisdiction over issues concerning reasonableness and necessity; the purpose of the regulation is to encourage payment of medical bills in cases that are, at least initially, medical only. *Krouse v. W.C.A.B. (Barrier Enters. Inc.)*, 837 A.2d 671, 674—675 (Pa. Cmwlth. 2003).

§ 127.406. Scope of review of UROs.

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

(b) UROs may not decide any of the following issues:

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

(2) Whether the employe is still disabled.

(3) Whether ''maximum medical improvement'' has been obtained.

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

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

(6) The appropriateness of the diagnostic or procedural codes used by the provider for billing purposes.

(7) Other issues which do not directly relate to the reasonableness or necessity of the treatment under review.

Notes of Decisions

Causal Relationship

The Workers' Compensation Appeal Board did not abuse its discretion by denying the claimant's request to remand the matter to the Workers' Compensation Judge to receive the ''after discovered'' utilization review organization (URO) determination, because the scope of review of a URO is

strictly limited to reviewing the reasonableness and necessity of medical treatment, the URO's decision that the physical therapy provided to the claimant was reasonable and necessary does not establish that the treatment was causally related to the claimant's work-related injury or that the claimant remains disabled by his work-related injury. *Corcoran v. Workers' Compensation Appeal Board*, 725 A.2d 868 (Pa. Cmwlth. 1999).

General Comment

Clearly, this regulation recognizes a distinction between an issue concerning causation as opposed to reasonableness and necessity of treatment. An action concerning causation cannot be raised before a URO; therefore, it must be raised in a petition that is intended to be heard directly by a WCJ. Likewise, an action concerning the reasonableness and necessity of treatment is to be raised in a request for UR that will be submitted to a URO. *Bloom v. Workmen's Compensation Appeal Board*, 677 A.2d 1314 (Pa. Cmwlth. 1996); appeal denied 684 A.2d 558 (Pa. 1996).

§ 127.407. Extent of review of medical records.

(a) In order to determine the reasonableness or necessity of the treatment under review, UROs shall obtain for review all available records of all treatment rendered by all providers to the employe for the work-related injury. However, the UR determination shall be limited to the treatment that is subject to review by the request.

(b) UROs may not obtain or review medical records of treatment which are not related to the work injury.

UR—INITIAL REQUEST

§ 127.451. Requests for UR—who may file.

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

Source

The provisions of this § 127.451 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial page (222313).

§ 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.

Source

The provisions of this § 127.452 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial page (222313).

Notes of Decisions

Service

The insurer cannot claim that the fee review should be dismissed as premature because it properly sought a request for a utilization review, where the hearing officer found that the health care provider presented uncontradicted testimony that it had never received notification that the bills would be subjected to a utilization review and that it was not provided with a utilization review report. *Royal Insurance v. Department of Labor and Industry, Bureau of Workers' Compensation, The Spine Center*, 728 A.2d 401 (Pa. Cmwlth. 1999).

§ 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.

Source

The provisions of this § 127.453 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial page (222314).

§ 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).

Source

The provisions of this § 127.454 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial page (222314).

§ 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).

Source

The provisions of this § 127.455 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial page (222314).

Cross References

This section cited in 34 Pa. Code § 127.454 (relating to initial requests for UR—reassignment).

§ 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.

Source

The provisions of this § 127.456 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial page (222314).

§ 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.

Source

The provisions of this § 127.457 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial page (222314).

§ 127.458. Obtaining authorization to release medical records.

If a request for UR does not have the necessary authorizations to release records attached to it, the URO may contact the providers or insurer to obtain the necessary authorizations.

§ 127.459. Obtaining medical records—provider under review.

(a) A URO shall request records from the provider under review in writing. The written request for records shall be by certified mail, return receipt requested. In addition, the URO may request the records from the provider under review by telephone.

(b) The medical records of the provider under review may not be requested from, or supplied by, any source other than the provider under review.

(c) The provider under review, or his agent, shall sign a verification that, to the best of his knowledge, the medical records provided constitute the true and complete medical chart as it relates to the employe's work-injury.

§ 127.460. Obtaining medical records—other treating providers.

(a) A URO shall request records from other treating providers in writing. In addition, the URO may request records from other treating providers by telephone.

(b) A provider, or his agent, who supplies medical records to a URO pursuant to this section shall sign a verification that, to the best of his knowledge, the medical records constitute the true and complete medical chart as it relates to the employe's work injury.

(c) If a URO is not able to obtain records directly from the other treating providers, it may obtain these records from the insurer, the employer or the employe.

(d) If an insurer, employer or employe supplies medical records to a URO under subsection (c), it shall sign a verification that, to the best of its knowledge, the records supplied are the complete set of records as received from the provider that relate to the work-injury and that the records have not been altered in any manner.

§ 127.461. Obtaining medical records—independent medical exams.

UROs may not request, and the parties may not supply, reports of independent medical examinations performed at the request of an insurer, employer, employe or attorney. Only the records of actual treating health care providers shall be requested by, or supplied to, a URO.

§ 127.462. Obtaining medical records—duration of treatment.

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

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

(a) The URO shall, within 30 days of receiving medical records, reimburse the provider for record copying costs at the rate specified by Medicare and for actual postage costs. The Bureau will publish the Medicare rate in the *Pennsylvania Bulletin* as a notice when the rate changes.

(b) Reproduction of radiologic films shall be reimbursed at the usual and customary charge. The cost of reproducing such films shall be itemized separately when the URO bills for performing the UR.

§ 127.464. Effect of failure of provider under review to supply records.

(a) If the provider under review fails to mail records to the URO within 30 days of the date of request of the records, the URO shall render a determination that the treatment under review was not reasonable or necessary, if the conditions set forth in subsection (b) have been met.

(b) Before rendering the determination against the provider, a URO shall do the following:

(1) Determine whether the records were mailed in a timely manner.

(2) Indicate on the determination that the records were requested but not provided.

(3) Adequately document the attempt to obtain records from the provider under review, including a copy of the certified mail return receipt from the request for records.

(c) If the URO renders a determination against the provider under subsection (a), it may not assign the request to a reviewer.

Notes of Decisions

URO

Because medical provider mailed claimant's health care records to Utilization Review Organization (URO) within 30 days of the request for such records, it was timely; language of regulation is clear that records must be ''mailed'' and not ''received'' within the 30 days of the date health care records are requested. *Sueta v. Workers' Comp. Appeal Bd. (City of Scranton and PMA Group)*, 943 A.2d 1017, 1021 (Pa. Cmwlth. 2008)

Workers' Compensation Judge (WCJ) lacked jurisdiction to hear claimant's appeal of Utilization Review Organization (URO) determination that treatments provided by claimant's physician were not reasonable or necessary; claimant's physician failed to provide medical records within 30 days to URO, and in the absence of a peer review report on the substantive merits of medical treatment, there is nothing for a WCJ to review. *Stafford v. Workers' Compensation Appeal Board (Advanced Placement Serv.)*, 933 A.2d 139, 142—143 (Pa. Cmwlth. 2007)

Claimant sought review of decision of workers' compensation judge dismissing, for lack of jurisdiction, his petition for review of utilization review organization (URO) determination that medical treatment was not reasonable or necessary based on failure of claimant's physician to provide medical records; WCJ had jurisdiction to determine the adequacy of URO's pursuit of requested medical records, URO's compliance with applicable regulatory procedures requirements, and whether claimant's medical provider complied with requirements since these issues did not involve a determination as to reasonableness and necessity of medical treatment. *Gazzola v. Workers' Compensation Appeal Board* (*Ikon Office Solutions*), 911 A.2d 662, 664, 665 (Pa. Cmwlth. 2006).

§ 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.

Source

The provisions of this § 127.465 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial page (203494).

§ 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.

Source

The provisions of this § 127.466 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial pages (203494) to (203495).

§ 127.467. Duties of reviewers—generally.

Reviewers shall apply generally accepted treatment protocols as appropriate to the individual case before them.

§ 127.468. Duties of reviewers—conflict of interest.

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

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

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

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

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

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

Cross References

This section cited in 34 Pa. Code § 127.455 (relating to requests for UR—conflicts of interest).

§ 127.469. Duties of reviewers—consultation with provider under review.

The URO shall give the provider under review written notice of the opportunity to discuss treatment decisions with the reviewer. The reviewer shall initiate discussion with the provider under review when such a discussion will assist the reviewer in reaching a determination. If the provider under review declines to discuss treatment decisions with the reviewer, a determination shall be made in the absence of such a discussion.

§ 127.470. Duties of reviewers—issues reviewed.

(a) Reviewers shall decide only the issue of whether the treatment under review is reasonable or necessary for the medical condition of the employe.

(b) Reviewers shall assume the existence of a causal relationship between the treatment under review and the employe's work-related injury. Reviewers may not consider or decide issues such as whether the employe is still disabled, whether maximum medical improvement has been obtained, quality of care or the reasonableness of fees.

Notes of Decisions

Assumption by Reviewer

The reviewing physicians properly assumed a causal relationship between the treatment and the back injury that was the only recognized injury. There was no requirement to make an assumption with respect to the non-back injuries; therefore, the conclusions that the treatment for the non-back injuries was neither reasonable nor necessary were properly accepted as competent and credible, satisfying the employer's burden. *Reinhardt v. Workers' Compensation Appeal Board*, (Mt. Carmel Nursing Center) 789 A.2d 871 (Pa. Cmwlth. 2002).

Causal Relationship

The Workers' Compensation Appeal Board did not abuse its discretion by denying the claimant's request to remand the matter to the workers' compensation judge to receive the ''after discovered'' utilization review organization (URO) determination, because the scope of review of a URO is strictly limited to reviewing the reasonableness and necessity of medical treatment, the URO's decision that the physical therapy provided to the claimant was reasonable and necessary does not establish that the treatment was causally related to the claimant's work-related injury or that the claimant remains disabled by his work-related injury. *Corcoran v. Workers' Compensation Appeal Board*, (Capital City Times Leader) 725 A.2d 868 (Pa. Cmwlth. 1999).

Quality of Care

Physician who performed utilization review did not violate statute prohibiting reviewers form considering or deciding ''quality of care'' issues by finding that medication prescribed by provider for workers' compensation claimant was unreasonable and unnecessary when he stated preference for safer medications; it was entirely appropriate for reviewer, in determining the reasonableness and necessity of a prescribed medication, to consider risk to the patient. *Sweigart v. Workers' Compensation Appeal Board (Burnham Corp.)*, 920 A.2d 962, 965 (Pa. Cmwlth. 2007)

§ 127.471. Duties of reviewers—finality of decisions.

(a) Reviewers shall make a definite determination as to whether the treatment under review is reasonable or necessary. Reviewers may not render advisory opinions as to whether additional tests are needed. In determining whether the treatment under review is reasonable or necessary, reviewers may consider whether other courses of treatment exist. However, reviewers may not determine that the treatment under review is unreasonable or unnecessary solely on the basis that other courses of treatment exist.

(b) If the reviewer is unable to determine whether the treatment under review is reasonable or necessary, the reviewer shall resolve the issue in favor of the provider under review.

Notes of Decisions

Basis of Utilization Reviewer's Testimony

Utilization reviewer's testimony that Claimant may have needed some other type of care did not violate the regulation disallowing determinations based solely on the fact that other courses of treatment existed; the reviewer also opined that the treatment rendered was unreasonable and unnecessary because it was of little value due to the time elapsed since the original injury. *Howrie v. Workers' Compensation Appeal Board (CMC Equip. Rental)*, 879 A.2d 820, 821 (Pa. Cmwlth. 2005).

Lack of Complete Medical History

The lack of a complete medical history does not, in itself, preclude the UR reviewer from assessing the reasonableness and necessity of treatment. As with any other evidence, the weight and credibility of the UR report are issues to be decided by the fact-finder. *Solomon v. Workers' Compensation Appeal Board (City of Philadelphia)*, 821 A.2d 215 (Pa. Cmwlth. 2003).

§ 127.472. Duties of reviewers—content of reports.

The written reports of reviewers shall contain, at a minimum, the following elements: a listing of the records reviewed; documentation of any actual or attempted contacts with the provider under review; findings and conclusions; and a detailed explanation of the reasons for the conclusions reached by the reviewer, citing generally accepted treatment protocols and medical literature as appropriate.

Notes of Decision

Burden of Proof

Report filed by physician who performed utilization review did not comply with regulation requiring report to contain detailed explanation of reasons for conclusion that treatment by provider was not reasonable or necessary; burden of proof was on reviewer to provide details explaining his conclusion and statement that provider failed to convince him that treatment was reasonable and necessary failed to meet the reviewer's burden of proof. *Sweigart v. W.C.A.B. (Burnham Corp.)*, 920 A.2d 962, 965—966 (Pa. Cmwlth. 2007)

§ 127.473. Duties of reviewers—signature and verification.

(a) Reviewers shall sign their reports. Signature stamps may not be used.

(b) Reviewers shall sign a verification pursuant to 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) that the reviewer personally reviewed the records and that the report reflects the medical opinions of the reviewer.

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

Reviewers shall forward their reports and all records reviewed to the URO upon completion of the report.

§ 127.475. Duties of UROs—review of report.

(a) UROs shall check the reviewer's report to ensure that the reviewer has complied with formal requirements (such as signature and verification).

(b) UROs shall ensure that all records have been returned by the reviewer.

(c) A URO may not contact a reviewer and attempt to persuade the reviewer to change the medical opinions expressed in a report.

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

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

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

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

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

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

Source

The provisions of this § 127.476 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial page (203497).

§ 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.

Source

The provisions of this § 127.477 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial pages (203497) to (203498).

§ 127.478. Record retention requirements for UROs.

(a) UROs shall retain records relating to URs for 1 year from the date that a determination was rendered. These records shall include, but are not limited to, the notice of assignment, all correspondence, all certified mail return receipts and documents, all medical records reviewed, the face sheet and the reviewer's report.

(b) The URO's files will be subject to inspection and audit by the Bureau without notice.

Cross References

This section cited in 34 Pa. Code § 127.625 (relating to record retention requirements for PROs).

§ 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).

Source

The provisions of this § 127.479 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial page (203498).

§ § 127.501—127.515. [Reserved].

Source

The provisions of these § § 127.501—127.515 reserved January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial pages (203498) to (203500) and (235597) to (235598).

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.

Source

The provisions of this § 127.551 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial page (235598).

Notes of Decisions

Procedure

Parties who fail to file a petition for reconsideration from an initial UR determination are not able to challenge the effect of such determination before a Workers' Compensation Judge. *Florence Mining Co. v. Workmen's Compensation Appeal Board* (McGinnis), 691 A.2d 984 (Pa. Cmwlth. 1997).

§ 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.

Source

The provisions of this § 127.552 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial page (233598).

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

Source

The provisions of this § 127.553 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial page (235598).

§ 127.554. Petition for Review by Bureau—no answer allowed.

No answer to the petition for review may be filed.

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

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

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

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

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

Source

The provisions of this § 127.555 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial page (203503).

§ 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.

Source

The provisions of this § 127.556 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial page (203503).

PEER REVIEW

§ 127.601. Peer review—availability.

(a) A Workers' Compensation judge may obtain an opinion from an authorized PRO concerning the necessity or frequency of treatment rendered under the act when one of the following exist:

(1) A petition for review of a UR determination has been filed.

(2) It is necessary or appropriate in other litigation proceedings before the Worker's Compensation judge. Peer review shall be deemed not to be necessary or appropriate if there is a pending UR of the same treatment.

(b) Nothing in subsection (a) requires a Workers' Compensation judge to grant a party's motion for peer review.

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

(a) A party may not make a motion for peer review if the same course of treatment has been submitted for UR.

(b) After making a motion for peer review, neither party may file a request for UR while the motion is pending. If the motion is not specifically ruled on within 10 days, then it shall be deemed denied.

(c) If the Workers' Compensation judge has not ruled on the motion within 10 days, or if the motion is denied, the parties shall be free to file requests for UR.

(d) If the motion is granted, the Workers' Compensation judge will proceed in accordance with § 127.604 (relating to peer review—forwarding a request to the Bureau).

§ 127.603. Peer review—interlocutory ruling.

The ruling on a motion for peer review shall be deemed interlocutory.

§ 127.604. Peer review—forwarding of request to Bureau.

(a) If the Workers' Compensation judge decides that peer review is necessary or appropriate, the Judge will forward a request for peer review to the Bureau on a form prescribed by the Bureau. The

Workers' Compensation judge will notify counsel, or the parties, if unrepresented, by serving a copy of the request for peer review upon them.

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

Cross References

This section cited in 34 Pa. Code § 127.602 (relating to peer review—procedure upon motion of party).

§ 127.605. Peer review—assignment by the Bureau.

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

(b) The Bureau will send a notice of assignment of the request for peer review to the PRO, the Workers' Compensation judge, counsel for the parties, or the parties, if unrepresented, and the health care provider under review.

§ 127.606. Peer review—reassignment.

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

(b) A PRO may not, under any circumstances, reassign a request for peer review to another PRO.

(c) A PRO shall return requests for peer review assigned to it by the Bureau if the PRO has a conflict of interest in the request assigned to it.

§ 127.607. Peer review—conflicts of interest.

(a) A PRO shall return a request for peer review to the Bureau for reassignment if the following apply:

(1) The PRO has a previous involvement with the patient or provider under review in the same matter.

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

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

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

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

(b) A PRO shall inform the reviewer assigned to perform peer review of the reviewer's obligation to notify the PRO of any potential or realized conflicts arising under § 127.615 (relating to duties of reviewers—conflict of interest)

§ 127.608. Peer review—withdrawal.

(a) A request for peer review shall be withdrawn only at the direction of the Workers' Compensation judge. The Workers' Compensation judge will notify the Bureau of the withdrawal in writing.

(b) The Bureau will promptly notify the PRO of the withdrawal. The Bureau will pay the costs incurred by the PRO prior to the withdrawal out of the Workmen's Compensation Administration Fund.

(c) If a previously withdrawn peer review request is resubmitted to the Bureau, the Bureau will assign the matter to the PRO which handled it prior to the withdrawal.

§ 127.609. Obtaining medical records.

(a) In cases where peer review has been requested on a petition for review of a UR determination, the Workers' Compensation judge may order the URO to forward all the records received and reviewed for the purposes of the UR to the PRO assigned to perform the peer review by the Bureau.

(b) In other cases, the PRO shall have 10 days from the date of the notice of assignment to subpoena records from treating providers.

§ 127.610. Obtaining medical records—independent medical exams.

PROs may not subpoena, request or be supplied with records of independent medical examinations performed at the request of an insurer, employer, employe or attorney. Only the records of actual treating health care providers may be subpoenaed by or supplied to a PRO.

§ 127.611. Obtaining medical records—duration of treatment.

PROs shall attempt to obtain records from all providers for the entire course of treatment rendered to the employe for the work-related injury which is the subject of the peer review request, regardless of the period of treatment under review.

§ 127.612. Effect of failure of provider under review to supply records.

(a) If the provider under review fails to mail records to the PRO within 30 days of the date of service of the subpoena for the records, the PRO shall report the provider's noncompliance with the subpoena to the Workers' Compensation judge.

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

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

Upon receipt of the medical records, the PRO shall forward the records, the request for peer review and the notice of assignment to a reviewer licensed by the Commonwealth in the same profession and Board-certified in the speciality or sub-specialty as the provider under review. Board-certification shall be by an accredited specialty board.

§ 127.614. Duties of reviewers—generally.

Reviewers shall apply generally accepted treatment protocols, as appropriate, to the individual case before them.

§ 127.615. Duties of reviewers—conflict of interest.

A reviewer shall return a review to the PRO for assignment to another reviewer if one or more of the following exist:

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

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

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

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

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

Cross References

This section cited in 34 Pa. Code § 127.607 (relating to peer review—conflicts of interest).

§ 127.616. Duties of reviewers—consultation with provider under review.

The PRO shall give the provider under review written notice of the opportunity to discuss treatment decisions with the reviewer. The reviewer shall initiate discussions with the provider under review when such a discussion will assist the reviewer in reaching a determination. If the provider under review declines to discuss treatment decisions with the reviewer, a determination shall be made in the absence of such a discussion.

§ 127.617. Duties of reviewers—issues reviewed.

(a) Reviewers shall decide only issues concerning the necessity and frequency of the treatment under review.

(b) Reviewers shall assume the existence of a causal relationship between the treatment under review and the employe's work-related injury. The reviewer may not consider or decide issues such as whether the employe is still disabled, whether maximum medical improvement has been obtained, quality of care or the reasonableness of fees.

§ 127.618. Duties of reviewers—finality of decisions.

(a) Reviewers shall make a definite determination as to the necessity and frequency of the treatment under review. Reviewers may not render advisory opinions as to whether additional tests are needed. In determining whether the treatment under review is necessary, reviewers may consider whether other coursers of treatment exist. However, reviewers may not render advisory opinions as to whether other courses of treatment are preferable.

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

§ 127.619. Duties of reviewers—content of reports.

The written reports of reviewers shall contain, at a minimum, the following elements: a listing of the records reviewed; documentation of any actual or attempted contacts with the provider under review; findings and conclusions; and a detailed explanation of the reasons for the conclusions reached by the reviewer, citing generally accepted treatment protocols and medical literature as appropriate.

§ 127.620. Duties of reviewers—signature and verification.

(a) Reviewers shall sign their reports. Signature stamps may not be used.

(b) Reviewers shall sign a verification under 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) that the reviewer personally reviewed the records and that the report reflects the medical opinions of the reviewer.

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

Reviewers shall forward their reports and all records reviewed to the PRO upon completion of the report.

§ 127.622. Duties of PRO—review of report.

(a) PROs shall check the reviewer's report to ensure that formal requirements, such as signature and verification, have been complied with by the reviewer.

(b) PROs shall ensure that all records have been returned by the reviewer.

(c) A PRO may not contact a reviewer and attempt to persuade the reviewer to change the medical opinions expressed in a report.

§ 127.623. Peer review—deadline for PRO determination.

A PRO shall complete its review and render its determination within 30 days of receipt of the medical records.

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

The PRO shall file its report directly with the Workers' Compensation judge and mail copies to all the parties listed on the notice of assignment by certified mail, return receipt requested.

§ 127.625. Record retention requirements for PROs.

PROs shall comply with all the record retention requirements specified in § 127.478 (relating to record retention requirements). Their files shall be subject to inspection and audit by the Bureau without notice.

§ 127.626. PRO reports—evidence.

The PRO report shall be a part of the record of the pending case. The Workers' Compensation judge will consider it as evidence but will not be bound by it.

§ 127.627. PRO reports—payment.

The PRO shall submit its itemized bill to the Workers' Compensation judge for approval. The judge will forward the bill to the Bureau with an order for payment. Payment will be made from the Workmen's Compensation Administration Fund.

AUTHORIZATION OF UROs AND PROs

§ 127.651. Application.

(a) Any organization seeking to be authorized as a URO or a PRO shall file an application on a form prescribed by the Bureau.

(b) Questions on the application shall be answered thoroughly and completely with the most recent information available. A rider may be attached if more space is necessary.

(c) The application shall be signed by a representative of the applicant and attested to as set forth on the application.

Cross References

This section cited in 34 Pa. Code § 127.401 (relating to purpose/review of medical treatment).

§ 127.652. Contents of an application to be authorized as a URO or PRO.

(a) An application to be authorized as a URO or PRO shall include the following:

(1) Ownership information, including the following:

(i) A disclosure of whether the applicant is owned or controlled, directly or indirectly, by a self-insured employer, a third-party administrator, a workers' compensation insurer or a provider.

(ii) A list of the owners of the proposed URO or PRO with a 5% or greater ownership interest; and a disclosure of whether any such owner is a director or officer of a self-insured employer, a third-party administrator, a workers' compensation carrier or is a provider.

(iii) A chart of the relationship between the proposed URO or PRO, its parent and other subsidiaries of the parent corporation, if the proposed URO or PRO is a subsidiary or affiliate of another corporation.

(iv) A list of directors and officers of the proposed URO or PRO; and a disclosure of whether any such director or officer is a director or officer of a self-insured employer, a third-party administrator, a workers' compensation carrier or is a provider.

(2) An organization chart listing reporting relationships and the positions supporting the operations of the URO or PRO, particularly in the areas of UR, quality assurance and case communication systems. An addendum to the chart shall describe how increased utilization of the URO or PRO services will affect staffing.

(3) A complete list of participating providers performing reviews for the URO or PRO:

(i) Identifying whether the provider is an employe or affiliate of or has entered into a contract or agreement with the URO or PRO.

(ii) Identifying the geographic area where the provider practices the provider's speciality.

(iii) Explaining how the contractual arrangements with providers ensure that the URO or PRO will be able to meet the requirements of the act and of this subchapter for UROs and PROs.

(iv) Establishing that it employs, is affiliated with, or has contracts with a sufficient number and specialty distribution of providers to perform reviews as required by the act and this subchapter.

(v) Including curriculum vitae of each reviewer.

(4) A copy of generic form contracts or letters of agreement used by the applicant to contract with participating providers.

(5) A description of the applicant's case communication system.

(6) A description of the applicant's utilization or peer review system which demonstrates how the applicant meets the standards of this subchapter.

(7) A description of the applicant's quality assurance system.

(8) A description of the applicant's fee structure.

(b) Subsequent to filing its application, the URO or PRO shall advise the Bureau of any changes to the information provided under subsection (a).

(c) The obligation of a URO or PRO to advise the Bureau of any changes to the criteria in subsection (a) shall continue subsequent to approval of its application for authorization by the Bureau.

Cross References

This section cited in 34 Pa. Code § 127.401 (relating to purpose/review of medical treatment).

§ 127.653. Decision on application.

(a) Approval of an applicant URO or PRO will be at the discretion of the Bureau.

(b) The Bureau, in rendering a decision on an application, will consider whether the applicant is capable of rendering impartial reviews and is capable of performing the responsibilities set forth in the act and this subchapter.

(c) The Bureau, in rendering a decision on an application, will consider whether an applicant is owned or controlled by another applicant, or whether more than one applicant is owned or controlled by the same person or entity. The Bureau will not approve more than one application for authorization as a URO or PRO in cases of common ownership or control.

(d) An applicant shall have the right to appeal a decision denying authorization as a URO or PRO within 30 days of the receipt of the decision. Untimely appeals will be dismissed without further action by the Bureau. A hearing will be conducted on the appeal as specified in § 127.670 (relating to hearings).

Cross References

This section cited in 34 Pa. Code § 127.401 (relating to purpose/review of medical treatment).

§ 127.654. Authorization periods.

The Bureau will issue authorization notices to approved UROs and PROs valid for 2 years from the date of issue, unless otherwise suspended or revoked for failure of the URO or PRO to comply with the act and this subchapter.

Cross References

This section cited in 34 Pa. Code § 127.401 (relating to purpose/review of medical treatment).

§ 127.655. Reauthorization.

(a) A URO or PRO shall apply for reauthorization no later than 120 days prior to the expiration date of its authorization.

(b) An application for reauthorization shall include information the Bureau may require to demonstrate that the URO or PRO has been operating in accordance with the act and this subchapter, and is able to continue to operate in accordance with the act and this subchapter.

Cross References

This section cited in 34 Pa. Code § 127.401 (relating to purpose/review of medical treatment).

§ 127.656. General qualifications.

A URO or PRO shall be capable of performing the responsibilities set forth in the act and this subchapter.

Cross References

This section cited in 34 Pa. Code § 127.401 (relating to purpose/review of medical treatment).

§ 127.657. Local business office.

A URO or PRO shall have a business office located within this Commonwealth which is staffed and open at a minimum from 9 a.m.—5 p.m. Monday through Friday, except for legal holidays.

Cross References

This section cited in 34 Pa. Code § 127.401 (relating to purpose/review of medical treatment).

§ 127.658. Accessibility.

A URO or PRO shall provide a toll-free telephone number and have adequate staff and telephone lines to handle inquiries from 9 a.m.—5 p.m. Monday through Friday, except for legal holidays. A URO or PRO shall also establish a mechanism to receive and record telephone calls during nonbusiness hours.

Cross References

This section cited in 34 Pa. Code § 127.401 (relating to purpose/review of medical treatment).

§ 127.659. Confidentiality.

(a) A URO or PRO shall have in effect policies and procedures to ensure, both that all applicable State and Federal laws to protect the confidentiality of individual medical records are followed, and that the organization does not improperly disclose or release confidential medical information.

(b) A URO or PRO shall have mechanisms in place that allow a provider to verify that an individual requesting information on behalf of the review organization is a legitimate representative of the organization.

Cross References

This section cited in 34 Pa. Code § 127.401 (relating to purpose/review of medical treatment).

§ 127.660. Availability of reviewers.

(a) A URO or PRO shall have available to it, by contractual arrangement or otherwise, the services of a sufficient number and specialty distribution of qualified physicians and other practitioner reviewers to ensure the organization can perform reviews as required by the act and this subchapter.

(b) A URO or PRO shall report changes in its list of reviewers to the Bureau within 30 days of the change.

Cross References

This section cited in 34 Pa. Code § 127.401 (relating to purpose/review of medical treatment).

§ 127.661. Qualifications of reviewers.

(a) Each reviewer utilized by a URO or PRO shall have an active practice.

(b) To qualify as an active practice the reviewer shall spend at least 20 hours a week treating patients in a clinical practice.

Cross References

This section cited in 34 Pa. Code § 127.401 (relating to purpose/review of medical treatment).

§ 127.662. Contracts with reviewers.

Contracts between a URO or PRO and reviewers shall contain, at a minimum, the following:

(1) A provision requiring the reviewer to cooperate with the UR, quality assurance and case communication systems established by the URO and PRO.

(2) A provision requiring the reviewer to abide by the confidentiality requirements of the URO or PRO.

(3) A provision specifying the contract termination rights and termination notice requirements for both the URO or PRO and the reviewer.

Cross References

This section cited in 34 Pa. Code § 127.401 (relating to purpose/review of medical treatment).

§ 127.663. UR system.

(a) UROs or PROs shall have a UR system which shall consist of documented criteria, standards and guidelines for the conduct of reviews undertaken under the act and this subchapter.

(b) The UR system shall ensure that the reviews undertaken under the act and this subchapter are impartial reviews.

Cross References

This section cited in 34 Pa. Code § 127.401 (relating to purpose/review of medical treatment).

§ 127.664. Quality assurance system.

A URO or PRO shall have a quality assurance system which shall consist of documented procedures to ensure that the URO/PRO and its reviewers comply with all the requirements specified in this subchapter.

Cross References

This section cited in 34 Pa. Code § 127.401 (relating to purpose/review of medical treatment).

§ 127.665. Case communication system.

A URO or PRO shall have a case communication system which shall ensure that all communications activities required by this chapter during a UR or peer review are performed by the URO or PRO.

Cross References

This section cited in 34 Pa. Code § 127.401 (relating to purpose/review of medical treatment).

§ 127.666. Annual reports.

A URO or PRO shall file an annul report with the Bureau on a form prescribed by the Bureau.

Cross References

This section cited in 34 Pa. Code § 127.401 (relating to purpose/review of medical treatment).

§ 127.667. Compensation policy.

(a) A URO or PRO shall charge a reasonable fee for its services on a flat fee or hourly basis. A URO or PRO may not charge for its services on a percentage or contingent fee basis.

(b) The Bureau will publish in the *Pennsylvania Bulletin*, on an annual basis, the range of fees charged by each URO and PRO for services performed under the act and this chapter during the preceding year.

Cross References

This section cited in 34 Pa. Code § 127.401 (relating to purpose/review of medical treatment).

§ 127.668. Suspension of assignments.

If the Bureau obtains information suggesting that a URO or PRO is not acting in accordance with the requirements of the act or this chapter, the Bureau may temporarily suspend the assignment of new reviews to the URO or PRO pending the outcome of an investigation. The suspension period may not exceed 60 days. The URO or PRO shall have the right to confer with the Chief of Medical Cost Containment Division.

Cross References

This section cited in 34 Pa. Code § 127.401 (relating to purpose/review of medical treatment).

§ 127.669. Revocation of authorizations.

(a) Upon investigation and following a conference with the Chief of the Medical Cost Containment Division, if the Bureau determines that a URO or PRO has violated the requirements of the act or this chapter, it may revoke the authorization of the URO or PRO to perform review functions under the act. Revocation of a URO or PRO's authority to perform reviews will be in writing and will advise the URO or PRO of its appeal rights.

(b) A URO or PRO whose authorization to perform reviews under the act has been revoked by the Bureau shall have the right to appeal the revocation within 30 days of the receipt of the Bureau's initial determination in accordance with the hearing process set forth in § 127.670 (relating to hearings).

Cross References

This section cited in 34 Pa. Code § 127.401 (relating to purpose/review of medical treatment).

§ 127.670. Hearings.

(a) The Director of the Bureau will assign appeals to decisions regarding a URO and PRO's authority to review medical treatment to a hearing officer who will schedule a de novo hearing on the appeal from the initial decision. The URO/PRO will receive reasonable notice of the hearing date, time and place.

(b) The hearing will be conducted in a manner to provide the URO/PRO and the Bureau the opportunity to be heard. The hearing officer will not be bound by strict rules of evidence. All relevant evidence of reasonably probative value may be received into evidence. Reasonable examination and cross-examination of witnesses will be permitted.

(c) Testimony will be recorded and a full record kept of the proceeding. The Bureau and the URO/PRO will be provided the opportunity to submit briefs addressing issues raised.

(d) The hearing officer will issue a written adjudication within 90 days following the close of the record. The decision will include all relevant findings and conclusions, and state the rationale for the decision. The decision will be served upon the URO/PRO, the Bureau and counsel of record. The decision will include a notification to the URO/PRO and the Bureau of further appeal rights to the Commonwealth Court.

(e) The URO/PRO or the Bureau, aggrieved by a hearing officer's adjudication, may file a further appeal to Commonwealth Court.

Notes of Decisions

De Novo Hearing Required

Whether utilization review organization's authorization to perform utilization reviews should be revoked was to be decided in a de novo hearing pursuant to regulations. Hearing officer's deference to prior decision by Bureau of Workers' Compensation to revoke URO's authorization was clearly an appellate standard of review and inappropriate in this case. *Chiro-Med v. Bureau of Workers' Compensation*, 879 A.2d 373, 381 (Pa. Cmwlth. 2005); appeal after remand 908 A.2d 980 (Pa. Cmwlth. 2006).

Utilization Review Mandatory

Workers' Compensation Judge lacks subject matter jurisdiction to determine the reasonableness and necessity of medical treatment if the matter has not first gone to utilization review. *County of Allegheny (John J. Kane Ctr.—Ross) v. Workers' Compensation Appeal Board (Geisler)*, 875 A.2d 1222, 1228 (Pa. Cmwlth. 2005).

Cross References

This section cited in 34 Pa. Code § 127.401 (relating to purpose/review of medical treatment); 34 Pa. Code § 127.653 (relating to decision on application); and 34 Pa. Code § 127.669 (relating to revocation of authorizations).

Subchapter D. EMPLOYER LIST OF DESIGNATED PROVIDERS

Sec.

§ 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.

Source

The provisions of this § 127.751 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial page (203515).

§ 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.

Source

The provisions of this § 127.752 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial pages (203515) to (203516).

§ 127.753. Disclosure requirements.

(a) The employer may not include on the list of designated health care providers a physician or other health care provider who is employed, owned or controlled by the employer or the employer's insurer, unless employment, ownership or control is disclosed on the list.

(b) For purposes of this section, ''employer's insurer'' means the insurer who is responsible for paying workers' compensation under the terms of the act.

§ 127.754. Prominence of list of designated providers.

If an employer chooses to establish a list of providers, the list shall be posted in prominent and readily accessible places at the worksite. These places include places used for treatment and first aid of injured employes and employe informational bulletin boards.

§ 127.755. Required notice of employe rights and duties.

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

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

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

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

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

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

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

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

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

necessary.

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

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

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

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

Source

The provisions of this § 127.755 amended January 16, 1998, effective January 17, 1998, 28 Pa.B. 329. Immediately preceding text appears at serial pages (203516) to (203517).

Notes of Decisions

Acknowledgment of Notice

When read in conjunction with section 306(f.1) of the Workers' Compensation Act (77 P. S. § 531(f.1)), § 127.755(d) (relating to required notice of employee rights and duties) requires that an employersecures written acknowledgment from the employee that he or she received written notice of the employee's rights and duties both upon hiring and after occurrence of an injury. *Department of Corrections v. Workers' Compensation Appeal Board*, 805 A.2d 633 (Pa. Cmwlth. 2002); appeal denied 813 A.2d 847 (Pa. 2002).

Notice Requirement

When read in conjunction with section 306(f.1)(1)(i) of the Workers' Compensation Act (77 P. S. § 531(f.1)(1)(i)), § 127.755(c) (relating to required notice of employee rights and duties) requires an employer to provide written notice of the employee's rights and duties on two occasions: first, upon hiring; and second, as soon as practicable after the employee suffers an injury. *Department of Corrections v. Workers' Compensation Appeal Board*, 805 A.2d 633 (Pa. Cmwlth. 2002).

Top

Positive
As of: February 12, 2020 7:56 PM Z

Armour Pharm. v. Bureau of Workers' (Wegman's Food Markets, Inc.)

Commonwealth Court of Pennsylvania

December 12, 2018, Argued; March 29, 2019, Decided; March 29, 2019, Filed

No. 1725 C.D. 2017

Reporter
206 A.3d 660 *; 2019 Pa. Commw. LEXIS 291 **; 2019 WL 1411204

Armour Pharmacy, Petitioner v. Bureau of Workers' Compensation Fee Review Hearing Office (Wegman's Food Markets, Inc.), Respondent

Prior History: [1]** Appealed from No. WCAIS Claim No. 7850477. State Agency: Bureau of Workers' Compensation.

Case Summary

Overview
HOLDINGS: [1]-It was for the Hearing Office to conduct a hearing on whether a person invoking the remedy set forth in 77 Pa. Stat. Ann. § 531 was a provider under the Workers' Compensation Act (Act), 77 Pa. Stat. Ann. § 1 et seq. It offended due process under Pa. Const. art. V, § 9 and the Act's scheme for resolving fee disputes to place the question of whether a putative provider was actually a "provider" beyond the reach of judicial review; [2]-Where the employer challenges a fee determination of the Medical Fee Review Section for the stated reason that the medical service was not rendered by a "provider" within the meaning of the Act, that threshold question must be decided by the Hearing Office.

Outcome
Judgment reversed and remanded.

LexisNexis® Headnotes

Workers' Compensation & SSDI > Administrative Proceedings > Hearings & Review

Workers' Compensation & SSDI > ... > Judicial Review > Standards of Review > Substantial Evidence

***HN1*[] Administrative Proceedings, Hearings & Review**

The scope of review of a decision by the Bureau's Hearing Office determines whether the necessary findings of fact are supported by substantial evidence, whether constitutional rights were violated, and whether the hearing officer committed an error of law. 2 Pa.C.S. § 704. Regarding questions of law, the scope of review is plenary and the standard of review is de novo.

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

***HN2*[] Medical Benefits, Authorized Treatment**

Employers are required to provide the medical care needed to treat an employee's work injury. 77 Pa. Stat. Ann. 531. To that end, employers must pay reasonable surgical and medical services, services rendered by physicians or other health care providers medicines and supplies, as and when needed. § 531(1)(i). Employers to make prompt payment on provider invoices for reasonable and necessary medical treatment of a claimant's work injury, and it establishes specific procedures

for resolving disputes about a particular invoice.

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

HN3 **Medical Benefits, Authorized Treatment**

Where an employer challenges a provider's treatment as neither reasonable nor necessary, it must seek utilization review pursuant to 77 Pa. Stat. Ann. 531. Where a provider does not receive payment within 30 days (and payment has not been stayed by an employer's utilization review request), it has recourse. The provider may file a fee review petition under § 531.

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

HN4 **Medical Benefits, Authorized Treatment**

The fee review process presupposes that liability has been established, either by voluntary acceptance by the employer or a determination by a WCJ. Neither the Workers' Compensation Act, 77 Pa. Stat. Ann. § 1 et seq., nor the medical cost containment regulations provide any authority for a fee review officer to decide the issue of liability in a fee review proceeding. 34 Pa. Code § 127.255(1), state that an application for fee review filed by a provider is premature and will be returned if the insurer denies liability for the alleged work injury. The issue for the fee review officer is the amount and timeliness of the payment made by an insurer. 34 Pa. Code § 127.251. An employer's liability for a claimant's work injury must be established before the fee review provisions can come into play. A fee review is designed to be a simple process with a very narrow scope limited to determining the relatively simple matters of amount or timeliness of payment for medical treatment. Whether an entity is a "provider" has been considered a question of employer liability and, thus, beyond the scope of a fee review proceeding.

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

Workers' Compensation & SSDI > Administrative Proceedings > Costs & Attorney Fees

HN5 **Medical Benefits, Authorized Treatment**

Claimants have an incentive to file a petition on behalf of a provider because when an insurer violates the Workers' Compensation Act, 77 Pa. Stat. Ann. § 1 et seq., by failing to make proper payment to a medical provider, the penalty is payable to the claimant. The absence of a direct statutory remedy for providers does not mean that the court may expand the scope of a fee review to create a remedy. The matter is one for the legislature, assuming there is a need for a provider to have another remedy.

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

HN6 **Medical Benefits, Authorized Treatment**

The Workers' Compensation Act (Act), 77 Pa. Stat. Ann. § 1 et seq., must be construed in accordance with due process of law. An employer may challenge a claimant's medical treatment as not medically necessary. Once it loses that challenge, however, it cannot use a Compromise and Release Agreement to deprive the provider of its right under the Act to prompt payment for services rendered to treat a claimant's work injury.

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

Workers' Compensation & SSDI > Administrative Proceedings > Hearings & Review

HN7 **Medical Benefits, Authorized Treatment**

The Workers' Compensation Act (Act), 77 Pa. Stat. Ann. § 1 et seq., and implementing regulations, as presently construed, empower an employer (or its insurer) to refuse payment for medical treatment of a claimant without having to make its case in an evidentiary hearing.

Constitutional Law > ... > Fundamental Rights > Procedural Due Process > Scope of Protection

HN8 **Procedural Due Process, Scope of Protection**

One asserting a due process violation must show an alleged constitutional deprivation caused by the exercise of some

right or privilege created by the State or by a rule of conduct imposed by the State or by a person for whom the State is responsible, and that the party charged with the deprivation must be a person who may fairly be said to be a state actor.

Constitutional Law > ... > Fundamental Rights > Procedural Due Process > Scope of Protection

HN9[] **Procedural Due Process, Scope of Protection**

Pa. Const. art. V, § 9 is consistent with inherent notions of due process.

Workers' Compensation & SSDI > Administrative Proceedings > Hearings & Review

Workers' Compensation & SSDI > Administrative Proceedings > Judicial Review

HN10[] **Administrative Proceedings, Hearings & Review**

The legislature has provided specificity to the administrative agency appeal process in the Administrative Agency Law, 2 Pa.C.S. §§ 501-508, 701-704. It defines an "adjudication" as a final order, decree, decision, determination or ruling by an agency affecting personal or property rights, privileges, immunities, duties, liabilities or obligations of any or all of the parties to the proceeding in which the adjudication is made. 2 Pa. C.S. §101. Thus, until a record is made of the proceedings, the adjudication is not valid. The reason behind this requirement is that judicial review without a proper record or a valid administrative adjudication is a premature interruption of the administrative process. When the governing statute has no specific provisions by which to obtain an administrative hearing on the agency's action, it is the Administrative Agency Law that provides a default mechanism for the provision of hearings and for appeals from administrative adjudications, which comport with due process requirements.

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

Workers' Compensation & SSDI > Administrative Proceedings > Hearings & Review

HN11[] **Medical Benefits, Authorized Treatment**

The implementing regulations guarantee prompt payment to a provider of medical treatment to employes with work-related injuries and illnesses. 34 Pa. Code § 127.1. They allow employers to challenge a course of treatment as not medically necessary. 34 Pa. Code, Chapter 127, Subchapter C (relating to medical treatment review). Employers may "downcode" provider charges in accordance with the cost containment requirements. 34 Pa. Code § 127.207. To implement this scheme, the Bureau of Workers' Compensation has created the Medical Fee Review Section to review provider complaints of untimely or inadequate payment, and it has created the Fee Review Hearing Office to conduct an evidentiary hearing on the validity of a fee review determination.

Constitutional Law > ... > Fundamental Rights > Procedural Due Process > Scope of Protection

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

Workers' Compensation & SSDI > Administrative Proceedings > Judicial Review

HN12[] **Procedural Due Process, Scope of Protection**

It offends due process, Pa. Const. art. V, § 9, as well as the scheme in Constitution as well as the scheme in the Workers' Compensation Act, 77 Pa. Stat. Ann. § 1 et seq., for resolving fee disputes to place the question of whether a putative provider is actually a "provider" beyond the reach of judicial review. Where the employer challenges a fee determination of the Medical Fee Review Section for the stated reason that the medical service was not rendered by a "provider" within the meaning of the Act, that threshold question must be decided by the Hearing Office. Jurisdiction, a quasi-judicial matter, is not to be decided by the Medical Fee Review Section, whose responsibility is solely administrative. Its inquiry is limited to the timeliness of the employer's payment (or denial) and the correct amount of reimbursement owed to the provider. 34 Pa. Code § 127.252.

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

Workers' Compensation & SSDI > Administrative Proceedings > Hearings & Review

HN13[] **Medical Benefits, Authorized Treatment**

It is for the Hearing Office to conduct a hearing on whether a person invoking the remedy set forth in 77 Pa. Stat. Ann. § 531 is a "provider" within the meaning of the Workers' Compensation Act, 77 Pa. Stat. Ann. § 1 et seq. This does not expand the scope of the fee review proceeding beyond timeliness and amount owed to a provider that has treated a claimant for his work injury. This does not allow the Hearing Office to determine the reasonableness of the medical care or service; the claimant's injury as work-related; or the employer's liability for a work injury. Where utilization review is sought, a fee determination is premature.

Counsel: Daniel J. Siegel, Havertown, for petitioner.

R. Burke McLemore, Jr., Harrisburg, for respondent.

Judges: BEFORE: HONORABLE MARY HANNAH LEAVITT, President Judge, HONORABLE RENÉE COHN JUBELIRER, Judge, HONORABLE ROBERT SIMPSON, Judge, HONORABLE PATRICIA A. McCULLOUGH, Judge, HONORABLE ANNE E. COVEY, Judge, HONORABLE MICHAEL H. WOJCIK, Judge, HONORABLE ELLEN CEISLER, Judge. CONCURRING OPINION BY JUDGE WOJCIK.

Opinion by: MARY HANNAH LEAVITT

Opinion

[*662] BY PRESIDENT JUDGE LEAVITT

Armour Pharmacy (Pharmacy) petitions for review of an adjudication of the Bureau of Workers' Compensation, Fee Review Hearing Office (Hearing Office) that vacated three determinations of the Bureau's Medical Fee Review Section that directed **[*663]** Wegman's Food Markets, Inc. (Employer) to reimburse Pharmacy for medications it had dispensed to Ryan Allem (Claimant). Employer challenged these fee determinations for the stated reason that Pharmacy was not a "provider" under the Pennsylvania Workers' Compensation Act (Act)[1] and, thus, not entitled to reimbursement. Concluding that the Bureau's Medical Fee Review Section lacked jurisdiction to determine whether Pharmacy was **[**2]** a "provider," the Hearing Office vacated the three determinations and dismissed Employer's appeal thereof. Pharmacy argues that the Hearing Office's adjudication has left it without a forum to challenge Employer's refusal to reimburse it for medications it dispensed to treat Claimant for his work injury, and this violates due process. We reverse and remand.

Background

On November 2, 2016, Bucks County Orthopedic Specialists prescribed Claimant a medical cream compound consisting of "Ketamine 10%, Flurbiprofen 10%, Gabapentin 10%, Cyclobenzaprine 3%, Bupivacaine 2%, [and] Transdermal Base (qs)" to treat his pain. Reproduced Record at 98a (R.R. __). Pharmacy dispensed the medication to Claimant on three occasions and thereafter invoiced Employer $3,634.17 for each prescription. Employer denied payment on the first invoice of November 30, 2016, for the following reasons:

> Charge for pharmaceuticals exceed the fees established by the fee schedule rates [and the usual customary and reasonable] rates. [Employer] does not cover pain cream compounds. A letter of medical necessity from your doctor is required if no alternatives are available.

R.R. 4a. Employer denied payment on the second **[**3]** invoice of December 29, 2016, stating as follows: "Request for treatment has been denied, withdrawn or refused" and "Denied: Utilization review filed." R.R. 16a. Likewise, Employer denied payment on the third invoice of March 1, 2017, stating as follows: "Denied: Medical records. Please resubmit with related medical records to: [Employer's address]." R.R. 40a.

Pharmacy filed three applications with the Bureau's Medical Fee Review Section, requesting a review of Employer's refusal to pay the three invoices for the compound cream. The Medical Fee Review Section found, first, that Employer had timely refused payment on each of the three invoices. Next, the Medical Fee Review Section found that the amount of payment owed under the required "Workers' Compensation fee calculations" was $3,322.16. R.R. 29a. The Medical Fee Review Section directed Employer to pay Pharmacy $3,322.16, plus ten percent interest on each invoice.

While the Medical Fee Review Section's review of the third

[1] Act of June 2, 1915, P.L. 736, *as amended*, 77 P.S. §§1-1041.4, 2501-2710.

application was pending, Employer filed a request for a *de novo* hearing on the first two administrative decisions. Employer identified the legal issue as follows:

> Lack of jurisdiction in the fee reviewers and lack **[**4]** of proper "provider" status on the part of the billing entity. Failure to bill at the proper statutory rates; and award in excess of statutory rates. Employer reserves right to amend to include additional grounds.

R.R. 44a. The Hearing Office assigned Employer's appeal to a hearing officer, and Employer's application was amended to include the Medical Fee Review Section's decision on Pharmacy's third application.

On July 24, 2017, Employer filed a motion to dismiss its own appeal. In support, **[*664]** Employer argued that because Pharmacy was not a "provider" within the meaning of the Workers' Compensation Act, the Hearing Office lacked jurisdiction. Pharmacy opposed the motion to dismiss, arguing that Employer had waived its "provider" argument by not raising the issue in its denial of Pharmacy's invoices or with the Medical Fee Review Section. By decision and order of October 30, 2017, the Hearing Office granted Employer's motion to dismiss. Relying on this Court's holding in *Selective Insurance Company of America v. Bureau of Workers' Compensation Fee Review Hearing Office (The Physical Therapy Institute)*, 86 A.3d 300 (Pa. Cmwlth. 2014), the Hearing Office held that it could not proceed on Employer's appeal because it challenged Pharmacy's status as a "provider," an issue beyond its jurisdiction. Likewise, the Medical Fee Review Section lacked jurisdiction **[**5]** to act upon Pharmacy's fee review applications and, thus, the Hearing Office vacated those determinations. Finally, the Hearing Office rejected Pharmacy's waiver argument, citing this Court's holding in *Pittsburgh Moose Lodge #46 v. Pittsburgh Moose Lodge # 46*, 109 Pa. Commw. 53, 530 A.2d 982 (Pa. Cmwlth. 1987), that subject matter jurisdiction is an issue that can be raised at any point in litigation.

On appeal,[2] Pharmacy argues that the Court should reconsider its ruling in *Selective Insurance* because it leaves a provider that renders medical treatment to a workers' compensation claimant without recourse whenever an employer refuses payment for the stated reason that the provider is not a "provider" within the meaning of the Act. Pharmacy suggests that this Court direct the Bureau of Workers' Compensation to promulgate a regulation to create a remedy by which a putative provider may obtain a determination of its status. A remedy is necessary because otherwise Pharmacy will be deprived of property without due process of law.[3]

Applicable Law

We begin with a review of the applicable provisions of the Act, which, *inter alia*, ***HN2***[] require employers to provide the medical care needed to treat an employee's work injury. Section 306(f.1) of the Act, 77 P.S. §531. To that end, employers must pay **[**6]** "reasonable surgical and medical services, services rendered by physicians or other health care *providers* . . . medicines and supplies, as and when needed." 77 P.S. §531(1)(i) (emphasis added). Section 109 of the Act defines a "health care provider" as follows:

> *[A]ny person, corporation, facility or institution licensed or otherwise authorized by the Commonwealth to provide health care services*, including, but not limited to, any physician, coordinated care organization, hospital, health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, psychologist, chiropractor **[*665]** *or pharmacist* and an officer, employe or agent of such person acting in the course and scope of employment or agency related to health care services.

77 P.S. §29 (emphasis added).

The Act requires employers to make prompt payment on provider invoices for reasonable and necessary medical treatment of a claimant's work injury, and it establishes specific procedures for resolving disputes about a particular invoice. Section 306(f.1)(5) states:

> The employer or insurer shall make payment and providers shall submit bills and records in accordance with the provisions of this section. *All payments to providers for treatment provided pursuant to this act shall be made* ***[**7]*** *within thirty (30) days of receipt of such bills and records unless the employer or insurer disputes the reasonableness or necessity of the treatment*

---

[2] ***HN1***[] This Court's scope of review of a decision by the Bureau's Hearing Office determines whether the necessary findings of fact are supported by substantial evidence, whether constitutional rights were violated, and whether the hearing officer committed an error of law. 2 Pa. C.S. §704; *Walsh v. Bureau of Workers' Compensation Fee Review Hearing Office (Traveler's Insurance Co.)*, 67 A.3d 117, 120 n.5 (Pa. Cmwlth. 2013). Regarding questions of law, our scope of review is plenary and our standard of review is *de novo*. *Sedgwick Claims Management Services, Inc. v. Bureau of Workers' Compensation, Fee Review Hearing Office (Piszel and Bucks County Pain Center)*, 185 A.3d 429, 433 n.2 (Pa. Cmwlth. 2018).

[3] The cost containment regulations forbid a provider from holding "an employe liable for costs related to care or services rendered in connection with a compensable injury under the act." 34 Pa. Code §127.211(a).

> *provided pursuant to paragraph (6)*. The nonpayment to providers within thirty (30) days for treatment for which a bill and records have been submitted shall only apply to that particular treatment or portion thereof in dispute; payment must be made timely for any treatment or portion thereof not in dispute. *A provider who has submitted the reports and bills required by this section and who disputes the amount or timeliness of the payment from the employer or insurer shall file an application for fee review* with the department no more than thirty (30) days following notification of a disputed treatment or ninety (90) days following the original billing date of treatment. If the insurer disputes the reasonableness and necessity of the treatment pursuant to paragraph (6), the period for filing an application for fee review shall be tolled as long as the insurer has the right to suspend payment to the provider pursuant to the provisions of this paragraph. Within thirty (30) days of the filing of such an application, the department shall render an administrative decision. **[**8]**

77 P.S. §531(5) (emphasis added). Subsection 6 states, in relevant part, as follows:

> *[D]isputes as to reasonableness or necessity of treatment by a health care provider shall be resolved in accordance with the following provisions*:
>
> (i) The reasonableness or necessity of all treatment provided by a health care provider under this act may be subject to prospective, concurrent or retrospective utilization review at the request of an employe, employer or insurer. The department shall authorize utilization review organizations to perform utilization review under this act. Utilization review of all treatment rendered by a health care provider shall be performed by a provider licensed in the same profession and having the same or similar specialty as that of the provider of the treatment under review.

77 P.S. §531(6) (emphasis added).

In sum, ***HN3***[] where an employer challenges a provider's treatment as neither reasonable nor necessary, it must seek utilization review pursuant to Section 306(f.1)(6) of the Act. Where a provider does not receive payment within 30 days (and payment has not been stayed by an employer's utilization review request), it has recourse. The provider may file a fee review petition under Section 306(f.1)(5) of the Act.

The case law has limited the **[**9]** scope of the fee review provisions of the Act. ***HN4***[] This Court has explained as follows:

> [T]he fee review process *presupposes* that liability has been established, either by voluntary acceptance by the employer or a determination by a WCJ [workers' **[*666]** compensation judge]. Neither the Act nor the medical cost containment regulations provide any authority for a fee review officer to decide the issue of liability in a fee review proceeding. The Department's regulations, at 34 Pa. Code §127.255(1), state that an application for fee review filed by a provider is premature and will be returned if "[t]he insurer denies liability for the alleged work injury." The issue for the fee review officer is the "amount and timeliness of the payment made by an insurer." 34 Pa. Code §127.251.

Nickel v. Workers' Compensation Appeal Board (Agway Agronomy), 959 A.2d 498, 503 (Pa. Cmwlth. 2008) (emphasis added). In short, an employer's liability for a claimant's work injury must be established before the fee review provisions can come into play. Our Supreme Court has underscored this point, stating that a fee review is designed to be a simple process with a "very narrow scope" limited to determining the "relatively simple matters" of "amount or timeliness" of payment for medical treatment. *Crozer Chester Medical Center v. Department of Labor and Industry, Bureau of Workers' Compensation, Health Care Services Review Division*, 610 Pa. 459, 22 A.3d 189, 196-97 (Pa. 2011).

Whether an entity is a "provider" has been considered a question **[**10]** of employer liability and, thus, beyond the scope of a fee review proceeding. In *Selective Insurance*, 86 A.3d 300, the employer sought review of two fee determinations of the Bureau's Medical Fee Review Section, which had awarded payment to the so-called "billing agency," *i.e.*, The Physical Therapy Institute. In its request for a hearing on these determinations, the employer asserted that The Physical Therapy Institute was not a provider but a billing entity. The Hearing Office dismissed the employer's petition, stating that it lacked jurisdiction to determine whether The Physical Therapy Institute was a provider, and this Court affirmed.

In so holding, we noted that the employer did not question the amount of the invoice but, instead, its liability to The Physical Therapy Institute. Since liability "must be established before a fee review proceeding can take place," we concluded that the issue was beyond the scope of a fee review proceeding and, thus, the Hearing Office "lacked jurisdiction to determine whether The Physical Therapy Institute [was] a medical provider." *Id.* at 304-05. Notably, the record in *Selective Insurance* showed that at least two claimants treating with The Physical Therapy Institute had filed penalty petitions **[**11]** to litigate the issue of whether The Physical Therapy Institute was a provider within the meaning of the Act. Given this record, this Court observed:

> ***HN5***[] Claimants have an incentive to file a petition on behalf of a provider because when an insurer violates the Act by failing to make proper payment to a medical provider, the penalty is payable to the claimant. *Westinghouse Electric Corporation v. Workers' Compensation Appeal Board (Weaver)*, 823 A.2d 209, 218 (Pa. Cmwlth. 2003). The absence of a direct statutory remedy for providers does not mean that the Court may expand the scope of a fee review to create a remedy. The matter is one for the legislature, assuming there is a need for a provider to have another remedy.

Id. at 305 n.9. With regard to The Physical Therapy Institute's recourse, the Court noted that the claimant "can file a petition to establish [an] [i]nsurer's liability to The Physical Therapy Institute, such as a review petition or a penalty petition." *Id.*

Thereafter, in *Physical Therapy Institute, Inc. v. Bureau of Workers' Compensation Fee Review Hearing Office*, 108 A.3d 957, 960 (Pa. Cmwlth. 2015), **[*667]** The Physical Therapy Institute argued that it was unfair for an employer to set aside a fee review determination by fabricating "an unfounded factual or legal issue, leaving providers with no recourse or remedy." (internal footnote omitted). However, we observed that

> the issue of whether [The] Physical Therapy Institute can establish itself **[**12]** as the provider entitled to payment, by contract with another provider, will be decided. Should [The] Physical Therapy Institute be adjudicated the provider, it can re-bill Insurer and proceed to fee review if an issue arises involving amount or timeliness of payment. Should either party believe that the other is effecting a fraud, it can pursue that claim in a legal action, such as a declaratory judgment action.

Id.

Recently, in *Armour Pharmacy v. Bureau of Workers' Compensation Fee Review Hearing Office (National Fire Insurance Company of Hartford)*, 192 A.3d 304 (Pa. Cmwlth. 2018) (*Armour I*), Pharmacy appealed a Hearing Office determination that it lacked jurisdiction over a fee review determination that, as here, involved the dispensing of a compound cream. Prior to the hearing on the employer's appeal of the fee determination, the employer and the claimant entered into a Compromise and Release (C&R) Agreement that obligated the employer to pay for previously incurred medical expenses that were determined to be reasonable and necessary for treatment of the claimant's injury. Notably, the C&R Agreement explicitly relieved the employer of liability for past, present or future prescriptions for compound creams. Before the Hearing Office, the employer argued that under the C&R Agreement, it had no liability to Pharmacy and, in any case, **[**13]** the Hearing Office lacked jurisdiction. Pharmacy petitioned for this Court's review, and we held in favor of Pharmacy.

We concluded that the employer could not use a C&R Agreement, to which Pharmacy was not a party, to deprive Pharmacy of its right to payment under the Act. Further, the employer had previously sought utilization review of the compound cream, and it was determined to be a reasonable and necessary treatment of the claimant's work injury. However, the employer did not appeal that determination. We construed the C&R Agreement, which established the employer's liability for past medical expenses, to require reimbursement for the compound cream.

The polestar in *Armour I* was that ***HN6***[] the Act must be construed in accordance with due process of law. An employer may challenge a claimant's medical treatment as not medically necessary. Once it loses that challenge, however, it cannot use a C&R Agreement to deprive the provider of its right under the Act to prompt payment for services rendered to treat a claimant's work injury.

Pharmacy Issues on Appeal

In its first issue, Pharmacy requests this Court to revisit or limit its holding in *Selective Insurance* and offers several reasons in **[**14]** support thereof. First, because the Bureau has not promulgated an appropriate regulation, a provider does not have a remedy where the employer questions its status as a "provider" under the Act. Second, the Court's observation in *Selective Insurance* that it is for the claimant to establish the employer's liability to a "provider" did not protect providers because they cannot compel claimants to file a petition. Indeed, a claimant may fear retaliation by the employer in the form of a termination, suspension or modification petition, and a claimant may not be able to **[*668]** afford counsel. Third, a claimant's interest does not necessarily coincide with a provider's interest, as was shown in *Armour I*.

Pharmacy argues that *Selective Insurance* should be limited to its facts, where the employer made a *prima facie* showing that the billing agency was not a provider. In *Selective Insurance*, the billing entity's status was a valid question because the invoices named two different physical therapists, one of whom had a business address different from that of The Physical Therapy Institute. By contrast, here, Pharmacy is both the provider *and* the billing entity, and Employer presented no evidence to support **[**15]** its averment to the contrary.

Pharmacy argues that *Physical Therapy Institute* is likewise

factually distinguishable because in that case, the employer had consistently maintained that the "provider" seeking payment did not render the physical therapy services recited in the invoice. By contrast, here, Employer has denied payment for several reasons, stating that the amounts exceeded the fee schedule and that compound creams are not medically necessary. At no point did Employer present any evidence that Pharmacy was not a provider.

Employer does not respond to these arguments, stating that it "has little to argue with [Pharmacy] in terms of what the statute says, what the regulations provide, and what prior case law emanating from this [C]ourt has held with respect to the fee review process." Employer Brief at 7.

In its second issue, Pharmacy contends that it is being denied its due process of law.[4] Specifically, ***HN7***[⬆] the Act and implementing regulations, as presently construed, empower an employer (or its insurer) to refuse payment for medical treatment of a claimant without having to make its case in an evidentiary hearing. In support of its due process claim, Pharmacy cites *Cruz v. Workers' Compensation Appeal Board (Philadelphia Club)*, 728 A.2d 413 (Pa. Cmwlth. 1999). There, we reversed **[**16]** a decision of a workers' compensation judge (WCJ) that a provider's treatment was unreasonable where the provider had not been given notice or an opportunity to participate in the deposition of an expert who opined that the treatment was unreasonable. We held that this was "fundamentally unfair" to the provider. *Id.* at 417. Likewise, here, Pharmacy contends that it is unfair to extinguish its statutory right to payment without an evidentiary hearing.

Pharmacy also directs our attention to *Caso v. Workers' Compensation Appeal Board (School District of Philadelphia)*, 790 A.2d 1078 (Pa. Cmwlth. 2002), *rev'd*, 576 Pa. 287, 839 A.2d 219 (Pa. 2003), which considered the certification of vocational experts. The Workers' Compensation Appeal **[*669]** Board (Board) held that the Act permitted WCJs to certify consultants as expert witnesses after the vocational interview has taken place. We disagreed and reasoned, *inter alia*, that the Bureau had to promulgate a regulation before WCJs could qualify vocational experts. Our Supreme Court reversed, holding that WCJs **[**17]** routinely make competency determinations about experts and were fully able to do so in this context. Pharmacy argues that our reasoning in *Caso* has continued viability to the extent it stands for the principle that this Court can direct the promulgation of a regulation. Pharmacy urges this Court to direct the Bureau to do so here so that providers can have a way to determine their status under the Act.

Employer argues, in response, that Pharmacy waived its due process claim. Employer observes that it was the only party that attempted to submit evidence, pointing to its May 25, 2017, subpoena request.[5] However, even if this Court accepted Pharmacy's constitutional challenge to the Act, that ruling will still leave Pharmacy without a remedy under the Act. Employer argues that the Court can avoid this dilemma with a construction of the Act that allows the Hearing Office "to entertain evidence on the issue of whether a purported 'provider' is, in fact, a 'provider' or 'the' provider in the first instance." Employer Brief at 11. Allowing the Hearing Office to make the threshold determination of "provider status" and its own subject matter jurisdiction saves the fee review provisions in the **[**18]** Act. However, this will not entitle Pharmacy to a hearing in this case because Pharmacy did not make a proffer of evidence relevant to its provider status before the Hearing Office.[6]

Analysis

The principles governing administrative practice and procedure in Pennsylvania are founded in our Constitution. Article V states as follows:

There shall be a right of appeal in all cases to a court of

---

[4] The Due Process Clause of the Fourteenth Amendment states as follows:

> No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States ... nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

U.S. CONST. amend. XIV, §1. The Pennsylvania Constitution also provides this protection. PA. CONST. art. I, §9.

HN8[⬆] One asserting a due process violation must show "an alleged constitutional deprivation caused by the exercise of some right or privilege created by the State or by a rule of conduct imposed by the State or by a person for whom the State is responsible, and that the party charged with the deprivation must be a person who may fairly be said to be a state actor." *American Manufacturers Mutual Insurance Company v. Sullivan*, 526 U.S. 40, 50, 119 S. Ct. 977, 143 L. Ed. 2d 130 (1999) (internal citations and quotation marks omitted).

[5] The subpoena request was denied because the Hearing Office concluded it lacked jurisdiction over the matter.

[6] Employer argues that it acted properly by requesting the subpoena instead of summarily requesting dismissal. Employer acknowledges that it also did not present evidence at the hearing, but it attempted to do so by requesting the subpoena. It contends that Pharmacy has no excuse for not putting forth a case on its provider status.

> record from a court not of record; and there shall also be a right of appeal from a court of record or from an administrative agency to a court of record or to an appellate court, the selection of such court to be as provided by law; and there shall be such other rights of appeal as may be provided by law.

PA. CONST. art. V, §9. As our Supreme Court has recently explained, ***HN9***[⬆] Article V, Section 9 "is consistent with inherent notions of due process." *Pittman v. Pennsylvania Board of Probation and Parole*, 639 Pa. 40, 159 A.3d 466, 474 (Pa. 2017).

HN10[⬆] The legislature has provided specificity to the administrative agency appeal process in the Administrative Agency Law, 2 Pa. C.S. §§501-508; 701-704. It defines an "adjudication" as a "final order, decree, decision, determination or ruling by an agency affecting personal or property rights, privileges, immunities, duties, liabilities or obligations of any or all of the parties to the proceeding in which the adjudication is made." **[**19]** 2 Pa. C.S. §101. It further provides:

> No adjudication of a Commonwealth agency shall be valid as to any party unless he shall have been afforded reasonable **[*670]** notice of a hearing and an opportunity to be heard. All testimony shall be stenographically recorded and a full and complete record shall be kept of the proceedings.

2 Pa. C.S. §504. Thus, "[u]ntil a record is made of the proceedings," the adjudication is not valid. *Turner v. Pennsylvania Public Utility Commission*, 683 A.2d 942, 946 (Pa. Cmwlth. 1996). "The reason behind this requirement is that judicial review without a proper record or a valid administrative adjudication is a premature interruption of the administrative process." *Id.* at 946. When the governing statute has "no specific provisions" by which to obtain an administrative hearing on the agency's action, it is the "the Administrative Agency Law [that] provides a default mechanism for the provision of hearings and for appeals from administrative adjudications, which comport with due process requirements." *Id.*

With these principles in mind, we turn to the fee review requirements established in the Act. ***HN11***[⬆] The implementing regulations guarantee prompt payment to a provider of medical treatment "to employes with work-related injuries and illnesses." 34 Pa. Code §127.1. They allow employers to challenge a course of treatment **[**20]** as not medically necessary. 34 Pa. Code, Chapter 127, Subchapter C (relating to medical treatment review). Employer may "downcode" provider charges in accordance with the cost containment requirements. 34 Pa. Code §127.207.

To implement this scheme, the Bureau of Workers' Compensation has created the Medical Fee Review Section to review provider complaints of untimely or inadequate payment, and it has created the Fee Review Hearing Office to conduct an evidentiary hearing on the validity of a fee review determination. 34 Pa. Code §127.257(a) ("A provider or insurer shall have the right to contest an adverse administrative decision on an application for fee review."). That hearing includes an examination of "all relevant evidence," and the testimony is "recorded and a full record kept of the proceeding." 34 Pa. Code §127.259(b), (d). The Hearing Office issues a "fee review adjudication" that "will include all relevant findings and conclusions, and state the rationale." 34 Pa. Code §127.260(a). These procedures ensure that the Bureau's adjudication comports with the requirements of the Administrative Agency Law, 2 Pa. C.S. §504, for a valid adjudication.

HN12[⬆] It offends due process, Article V, Section 9 of the Pennsylvania Constitution as well as the Act's careful scheme for resolving fee disputes to place the question of whether a putative provider **[**21]** is actually a "provider" beyond the reach of judicial review. We hold that where the employer challenges a fee determination of the Medical Fee Review Section for the stated reason that the medical service was not rendered by a "provider" within the meaning of the Act, that threshold question must be decided by the Hearing Office. Jurisdiction, a quasi-judicial matter, is not to be decided by the Medical Fee Review Section, whose responsibility is solely administrative. Its inquiry is limited to the timeliness of the employer's payment (or denial) and the correct amount of reimbursement owed to the provider. 34 Pa. Code §127.252.

This holding is consistent with precedent in analogous situations. It has long been held, for example, that a challenge to an arbitrator's jurisdiction over a grievance brought under a collective bargaining agreement must be presented to the arbitrator in the first instance. *Pennsylvania Labor Relations Board v. Bald Eagle Area School District*, 499 Pa. 62, 451 A.2d 671 (Pa. 1982). If a party is not satisfied, **[*671]** the question may then be raised in judicial review. *Id.*

J.G. v. Department of Public Welfare, 795 A.2d 1089 (Pa. Cmwlth. 2002), is also instructive. In *J.G.*, we considered a challenge to the administrative hearing procedures under the Child Protective Services Law,[7] which established a ChildLine and Abuse Registry consisting of "indicated" and "founded" **[**22]** reports of child abuse. 23 Pa. C.S. §6331(2) (requiring the Department to establish "[a] Statewide central register of child abuse"). The Child Protective Services Law provided that a perpetrator of child

[7] 23 Pa.C.S. §§6301-6386.

abuse named in an indicated report could have an administrative hearing to challenge the report. However, the statute did not provide this opportunity to perpetrators named in a founded report, which is issued following a judicial adjudication of abuse in a criminal conviction or a civil dependency proceeding. In *J.G.*, a child was adjudicated a "dependent child" because of abuse suffered while in the care of both parents. The mother sought a hearing to challenge the founded report that named her as a perpetrator, but the Department dismissed her hearing request as not authorized by the Child Protective Services Law.

We reversed and remanded the matter to the Department for a hearing. We held that the omission of a hearing on a founded report in the Child Protective Services Law was not dispositive. We looked to the Administrative Agency Law, which defines an "adjudication" as a "final order, decree, decision, determination or ruling by an agency affecting personal or property rights, [or] privileges ... **[**23]** of any or all of the parties to the proceeding in which the adjudication is made." 2 Pa. C.S. §101.[8] Further, an "adjudication" is not valid except where the party has "reasonable notice of a hearing and an opportunity to be heard." 2 Pa. C.S. §504. In *J.G.*, the child dependency adjudication did not "specifically find that [the mother] was guilty of abuse." *J.G.*, 795 A.2d at 1093. A founded report naming the mother as a perpetrator of child abuse in the absence of a hearing on that disputed fact would constitute an invalid adjudication. Accordingly, this Court filled the lacuna in the Child Protective Services Law with the default hearing required by the Administrative Agency Law and directed the Department to conduct a hearing on the mother's challenge to the founded report.

Likewise, here, ***HN13***[] it is for the Hearing Office to conduct a hearing on whether a person invoking the remedy set forth in Section 306(f.1)(5) is a "provider" within the meaning of the Act. In no way does this holding expand the scope of the fee review proceeding beyond timeliness and amount owed to a provider that has treated a claimant for his work injury. This holding does not allow the Hearing Office to determine the reasonableness of the medical care or service; the claimant's injury **[**24]** as work-related; or the employer's liability for a work injury. Where utilization review is sought, a fee determination is premature.[9]

[*672] Our holding does not limit the determination of the status of a "provider" to a fee review proceeding. In appropriate cases, this question may also be determined by a workers' compensation judge in the course of a claim or penalty petition proceeding. This was the case in *Selective Insurance*. Where the employer's liability for medical treatment is established without a determination on the status of a putative provider, then this question can be addressed by the Hearing Office where raised by the employer. *Selective Insurance* is distinguishable, but to the extent *Selective Insurance* is inconsistent with our holding here, it is overruled.[10]

Conclusion

For all of the above-stated reasons, we reverse the Hearing Office's adjudication and remand the matter for a determination of whether Pharmacy is a provider within the meaning of the Act.

MARY HANNAH LEAVITT, President Judge

ORDER

AND NOW, this 29th day of March, 2019, the order of the Bureau of Workers' Compensation Fee Review Hearing Office, dated October 30, 2017, is hereby REVERSED and this matter **[**25]** is REMANDED for further proceedings in accordance with the attached opinion.

Jurisdiction relinquished.

MARY HANNAH LEAVITT, President Judge

Concur by: MICHAEL H. WOJCIK

Concur

[8] This Court held that a "final determination or order" that "brands" a named perpetrator as a child abuser in a statewide central registry affects personal rights and, as such, constitutes an adjudication. *J.G.*, 795 A.2d at 1092. The impact on personal rights was a legal determination based upon a review of the Child Protective Services Law. A hearing on the extent to which a founded report "affects" a named perpetrator's personal rights was neither appropriate nor necessary.

[9] Employer denied payment on Pharmacy's December 29, 2016, invoice because, *inter alia*, it sought utilization review. If that utilization review has not been completed, then the Hearing Office should hold Employer's hearing request until the utilization review is completed.

[10] We reject Employer's argument that Pharmacy waived the question of its status as a "provider" under the Act. Employer's motion to dismiss was granted without evidence from either party.

CONCURRING OPINION BY JUDGE WOJCIK

I join in the result reached by the Majority. By limiting the holdings in *Selective Insurance Company of America v. Bureau of Workers' Compensation Fee Hearing Office (The Physical Therapy Institute)*, 86 A.3d 300 (Pa. Cmwlth. 2014), and *Physical Therapy Institute, Inc. v. Bureau of Workers' Compensation Fee Hearing Office*, 108 A.3d 957 (Pa. Cmwlth. 2015), this decision fills a gap in the statutory and regulatory scheme.

However, I write separately to object to the Court's reliance on *J.G. v. Department of Public Welfare*, 795 A.2d 1089 (Pa. Cmwlth. 2002), as support in this matter. I note that the two cases are inapposite, as the petitioner in the present appeal *seeks an adjudication* of its statutory rights. In sharp contrast, we held in *J.G.* that the petitioner was entitled to an administrative appeal *from an adjudication*.[1]

[*673] Accordingly, I concur in the result only.

MICHAEL H. WOJCIK, Judge

End of Document

[1] Additionally, I disagree with the Majority's interpretation of *J.G.*, because the issue of whether a founded report of child abuse constitutes an "adjudication" was neither litigated nor decided by the Court in *J.G.* Majority, slip op. at 16-17 and n.7. Rather, it was *presumed*, apparently based on the Court's misapprehension of the consequences: "A founded report of child abuse is an 'adjudication' as it is a final determination that affects a named perpetrator's personal rights by branding him or her as a child abuser in **[**26]** a Statewide register of child abuse." 795 A.2d at 1092. The quoted language reflects a belief that a named perpetrator necessarily suffers great harm to his or her reputation. However, the presumption of harm underlying the analysis in *J.G.* is inconsistent with our Supreme Court's analysis in *G.V. v. Department of Public Welfare*, 625 Pa. 280, 91 A.3d 667 (Pa. 2014), and *O'Rourke v. Commissioner of Motor Vehicles*, 33 Conn. App. 501, 636 A.2d 409 (Pa. 1994), and it is unsupported by the Child Protective Services Law, 23 Pa. C.S. §§6301-6386.

Armour Pharm. v. Bureau of Workers' Comp. Fee Review Hearing Office (Nat'l Fire Ins. Co. of Hartford)

Commonwealth Court of Pennsylvania

June 4, 2018, Argued; August 7, 2018, Decided; August 7, 2018, Filed

No. 1613 C.D. 2017

Reporter
192 A.3d 304 *; 2018 Pa. Commw. LEXIS 368 **; 2018 WL 3732390

Armour Pharmacy, Petitioner v. Bureau of Workers' Compensation Fee Review Hearing Office (National Fire Insurance Company of Hartford), Respondent

Outcome
Vacated and remanded.

Prior History: [1]** Appealed from No. DSP-7030875-2. State Agency Bureau of Workers' Compensation Fee Review Hearing Office.

Case Summary

Overview
HOLDINGS: [1]-In a case in which a pharmacy petitioned for review of an adjudication of the hearing office that vacated a fee review determination that the pharmacy was entitled to be paid $6,644.30, plus interest, for prescription cream medication it had dispensed to a claimant, the court concluded that a 2016 compromise and release (C&R) agreement required the claimant's employer to pay for all reasonable and necessary medical expenses incurred prior to hearing, and it was for the utilization review organization to decide whether the compound cream treatment was reasonable and necessary; [2]-A C&R agreement cannot be employed to avoid the procedures in the Workers' Compensation Act for challenging a provider's invoice or a fee review determination that the invoice must be paid.

LexisNexis® Headnotes

Workers' Compensation & SSDI > ... > Judicial Review > Standards of Review > Substantial Evidence

***HN1*[] Standards of Review, Substantial Evidence**

Appellate review in medical fee review cases determines whether constitutional rights were violated, whether an error of law was committed, or whether the necessary findings of fact were supported by substantial evidence. Regarding questions of law, the scope of review is plenary and the standard of review is de novo.

Workers' Compensation & SSDI > Administrative Proceedings > Hearings & Review

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits

***HN2*[] Administrative Proceedings, Hearings & Review**

The Pennsylvania Workers' Compensation Act, 77 Pa. Stat. Ann. § 1 et seq., requires employers to make prompt payment on provider invoices for reasonable and necessary medical treatment of a claimant's work injury. The Act also establishes

specific procedures for resolving disputes between a provider and an employer about whether the treatment that generated the invoice actually meets that standard.

Workers' Compensation & SSDI > Administrative Proceedings > Hearings & Review

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits

HN3 **Administrative Proceedings, Hearings & Review**

Where an employer challenges a provider's treatment under the Pennsylvania Workers' Compensation Act, 77 Pa. Stat. Ann. § 1 et seq., as neither reasonable nor necessary, it must seek utilization review pursuant to § 301(f.1)(6) of the Act. 77 Pa. Stat. Ann. § 531(5). Until the utilization review determination is issued, the employer may suspend payment to the provider. § 531(5). Where a provider does not receive payment within 30 days (and payment has not been stayed by an employer's utilization review request), it has recourse. The provider may file a fee review petition under § 301(f.1)(5), which gives that provider a right to prompt payment for reasonable and necessary medical treatment of a claimant's accepted work injury. Notably, a fee review proceeding cannot be used to establish that a claimant has a work-related injury for which the employer has liability.

Workers' Compensation & SSDI > Administrative Proceedings > Hearings & Review

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits

HN4 **Administrative Proceedings, Hearings & Review**

The fee review process under the Pennsylvania Workers' Compensation Act, 77 Pa. Stat. Ann. § 1 et seq., presupposes that liability has been established, either by voluntary acceptance by the employer or a determination by a workers' compensation judge. Neither the Act nor the medical cost containment regulations provide any authority for a fee review officer to decide the issue of liability in a fee review proceeding. The Department of Labor & Industry's regulations, at 34 Pa. Code § 127.255(1), state that an application for fee review filed by a provider is premature and will be returned if the insurer denies liability for the alleged work injury. The issue for the fee review officer is the amount and timeliness of the payment made by an insurer. 34 Pa. Code § 127.251. Any dispute about whether a claimant has a work injury, or the scope of that injury, must be litigated in accordance with the procedures of the Act for a claim petition proceeding.

Workers' Compensation & SSDI > Administrative Proceedings > Settlements

HN5 **Administrative Proceedings, Settlements**

A valid compromise and release agreement is binding upon the parties.

Workers' Compensation & SSDI > Administrative Proceedings > Settlements

HN6 **Administrative Proceedings, Settlements**

The scope of § 449(a) of the Pennsylvania Workers' Compensation Act, 77 Pa. Stat. Ann. § 1 et seq., is limited to parties interested that wish to compromise and release any and all liability under the Act. 77 Pa. Stat. Ann. § 1000.5(a). This does not include the provider.

Constitutional Law > ... > Fundamental Rights > Procedural Due Process > Scope of Protection

HN7 **Procedural Due Process, Scope of Protection**

The Due Process Clause of the Fourteenth Amendment to the United States Constitution requires at a minimum that the deprivation of life, liberty, or property by adjudication must be preceded by notice and opportunity for hearing appropriate to the nature of the case. States are required to make efforts to provide actual notice to all parties whose interests are affected by proceedings before a tribunal.

Constitutional Law > ... > Fundamental Rights > Procedural Due Process > Scope of Protection

HN8 **Procedural Due Process, Scope of Protection**

An elementary and fundamental requirement of due process in any proceeding which is to be accorded finality is notice reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections. The notice must be of such nature as reasonably to convey the required

information, and it must afford a reasonable time for those interested to make their appearance.

Constitutional Law > ... > Fundamental Rights > Procedural Due Process > Scope of Protection

Workers' Compensation & SSDI > Administrative Proceedings > Hearings & Review

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits

HN9[] **Procedural Due Process, Scope of Protection**

The utilization review and fee review procedures of the Pennsylvania Workers' Compensation Act, 77 Pa. Stat. Ann. § 1 et seq., have been designed to comport with due process. They give both the employer and provider an opportunity to be heard on the factual question of whether a provider's treatment was reasonable and necessary and, thus, required to be paid for by the employer.

Workers' Compensation & SSDI > Administrative Proceedings > Settlements

HN10[] **Administrative Proceedings, Settlements**

The parties to a compromise and release (C&R) agreement can bind each other, but they cannot release themselves from liability to a person who is not a party to the C&R agreement and who has been given neither notice nor opportunity to be heard on the C&R agreement.

Counsel: Daniel J. Siegel, Havertown, for petitioner.

James R. Andrzejewski, Wyomissing, for respondent.

Judges: BEFORE: HONORABLE MARY HANNAH LEAVITT, President Judge, HONORABLE PATRICIA A. McCULLOUGH, Judge, HONORABLE CHRISTINE FIZZANO CANNON, Judge. OPINION BY PRESIDENT JUDGE LEAVITT.

Opinion by: MARY HANNAH LEAVITT

Opinion

[*305] OPINION BY PRESIDENT JUDGE LEAVITT

Armour Pharmacy (Pharmacy) petitions for review of an adjudication of the Bureau of Workers' Compensation, Fee Review Hearing Office (Hearing Office) that vacated a fee review determination by the Bureau's Medical Fee Review Section that Pharmacy was entitled to be paid $6,644.30, plus interest, for medication it had dispensed to Mark Kraayenbrink (Claimant). The Hearing Office did so because Claimant had released his employer from liability for this particular treatment in a Compromise and Release (C&R) Agreement that was approved by a Workers' Compensation Judge (WCJ). Notably, this C&R Agreement was executed after the fee review determination was issued and while the employer's challenge thereto was pending. Pharmacy argues that the C&R Agreement cannot be used **[**2]** to set aside a fee review determination; rather, a fee review determination in favor of a provider may be set aside only by following the fee review procedures set forth in the **[*306]** Workers' Compensation Act[1] (Act). Pharmacy also argues that the C&R Agreement, to which it was not a party, deprived it of its property rights in violation of the Act and in violation of Pharmacy's constitutional guarantee of due process of law. We vacate and remand.

Background

In 1999, Claimant sustained a back injury while working for Cabinet Transport, Inc. (Employer). In 2000, Claimant and Employer entered into a C&R Agreement that settled Claimant's disability compensation but left Employer responsible for Claimant's medical treatment. Since 2000, Employer has covered Claimant's medical treatment.[2]

In 2015, Employer requested a utilization review of a topical compound cream prescribed by Jason Bundy, M.D. to treat Claimant's work injury, *i.e.*, neuropathy. This compounded cream consisted of "ketamine 10%, flurbiprofen 10%, gabapentin 10%, cyclobenzaprine 3%, bupivacaine 2% within

[1] Act of June 2, 1915, P.L. 736, *as amended*, 77 P.S. §§1-1041.4, 2501-2708.

[2] The insurer responsible for Claimant's workers' compensation benefits is National Fire Insurance Company of Hartford.

a transdermal base" and was to be applied as needed. Utilization Review Determination at 5; Reproduced Record at 7a (R.R. __). On September 9, 2015, the utilization **[**3]** review organization determined that the compound cream prescribed by Dr. Bundy to Claimant was reasonable and necessary to treat Claimant's accepted work injury. Employer did not appeal.

In early 2016, Dr. Bundy prescribed the identical compound cream to Claimant. Pharmacy dispensed the cream and billed Employer on April 19, 2016, but Employer refused to pay Pharmacy's invoice, "based on utilization review." R.R. 14a. Pharmacy filed a timely fee review application with supporting documents. On July 25, 2016, the Medical Fee Review Section of the Bureau determined that Employer owed Pharmacy $6,644.30, plus ten percent interest to be calculated as of the 30th day after Pharmacy had submitted its invoice for payment. On August 5, 2016, Employer requested a hearing to contest the fee review determination on the following grounds:

> Claimant has been prescribed compound medications which are overly inflated in price, with self-interest from the prescriber, are not FDA approved and generally contain the same medications that can be taken orally at a significant price reduction. The medicine is not reasonable nor medically necessary.

R.R. 32a. The hearing requested by Employer was convened on **[**4]** November 18, 2016, before a hearing officer appointed by the Hearing Office.

At the hearing's inception, Employer alleged that Dr. Bundy had a financial interest in Pharmacy and, thus, his prescription constituted an unlawful "self-referral." Notes of Testimony at 6 (N.T. __); R.R. 86a. Noting that the question of whether the provider self-referral prohibition in the Act[3] applies to pharmacies was pending in **[*307]** several cases, the Hearing Officer stated that he would defer ruling on that question. Accordingly, the Hearing Officer instructed Employer to "move on" to the "non-self-referral issues." N.T. at 8; R.R. 88a.

Employer then presented a copy of a C&R Agreement, which was approved by a WCJ on October 28, 2016 (2016 C&R Agreement), three months after the Medical Fee Review Section directed Employer to pay Pharmacy $6,644.30 plus interest.[4] The 2016 C&R Agreement states, in relevant part, as follows:

> Upon approval of this Agreement Defendant/ Employer shall pay reasonable, necessary and related medical expenses incurred before the hearing date. No past, present or future benefits shall be paid for any compounded prescription cream, including but not limited to compound prescription creams prescribed by physician Dr. Jason Bundy. (see Addendum)

2016 C&R Agreement, ¶10; R.R. 59a (emphasis added). The corresponding Addendum stated:

> After an investigation, Defendants have reason to believe that Dr. Bundy has a financial interest in [Pharmacy] in violation of [S]ection 306(f.1)(3)(iii) of the Act[, 77 P.S. §531(3)(iii)] **[**6]** and Sections 127.301 and 127.302 of the Medical Cost Containment Regulations[, 34 Pa. Code §§ 127.301-127.302]. Consistent with Section 306(f.1)(7) [of the Act, 77 P.S. §531(7)] neither provider Dr. Bundy nor [Pharmacy] shall hold the Claimant responsible for any charges related to the above mentioned compounding prescription cream.

Addendum to ¶10, R.R. 62a. Employer asserted that paragraph 10 of the 2016 C&R Agreement relieved it of liability to pay Pharmacy's invoice for the compound creams and, thus, the Hearing Officer lacked jurisdiction to proceed further on Employer's request for a hearing to contest the fee review determination in favor of Pharmacy.

Pharmacy replied that it was not a party to the 2016 C&R Agreement, which was executed long after Pharmacy had dispensed the medication and the Medical Fee Review Section had made its determination that Employer was liable for the cost plus interest. Pharmacy contended that a C&R Agreement could not be used "to invalidate or subvert a legal process" established in the Act for a review of a provider's

---

[3] Section 306(f.1)(3)(iii) of the Act provides:

> Notwithstanding any other provision of law, *it is unlawful for a provider to refer a person for laboratory, physical therapy, rehabilitation, chiropractic, radiation oncology, psychometric, home infusion therapy or diagnostic imaging, goods or services pursuant to this section if the provider has a financial interest with the person or in the entity that receives the referral*. It is unlawful for a provider to enter into an arrangement or scheme such as a cross-referral arrangement, which the provider knows or should know has a principal purpose of assuring referrals by the provider to **[**5]** a particular entity which, if the provider directly made referrals to such entity, would be in violation of this section. No claim for payment shall be presented by an entity to any individual, third-party payer or other entity for a service furnished pursuant to a referral prohibited under this section.

77 P.S. §531(3)(iii) (emphasis added).

[4] Specifically, the Medical Fee Review Section ordered Employer to pay Pharmacy on July 25, 2016. On September 15, 2016, Employer petitioned for approval of the C&R Agreement. It was approved by the WCJ on October 28, 2016, shortly before the hearing on Employer's challenge to the fee review determination.

fees. N.T. at 13-14; R.R. 93a-94a. Pharmacy further contended that its vested right to the payment ordered by the Medical Fee Review Section could not be "extinguished" without notice and an opportunity to be heard. *Id.*

At the direction **[**7]** of the Hearing Officer, the parties submitted briefs on the threshold question of whether the 2016 C&R Agreement deprived the Hearing Officer of jurisdiction over Employer's challenge to the fee review determination. On October 3, 2017, the Hearing Officer issued the instant adjudication. He concluded that in light of the 2016 C&R Agreement, which extinguished Employer's past, present and future liability for compound **[*308]** creams, the Medical Fee Review Section's "Administrative Determination cannot stand." Hearing Office Adjudication at 6. In response to Pharmacy's due process arguments, the Hearing Officer explained that he lacked the authority to address constitutional questions. Likewise, he lacked jurisdiction to consider the merits of the 2016 C&R Agreement, which was a matter committed solely to the discretion of the WCJ. Accordingly, the Hearing Officer granted Employer's motion to dismiss and vacated the July 25, 2016, fee review determination that Employer owed Pharmacy $6,644.30, plus interest, for the compound cream prescribed to Claimant. Pharmacy then petitioned for this Court's review of the Hearing Office's adjudication.[5]

On appeal, Pharmacy challenges the Hearing **[**8]** Office's adjudication as violative of Pharmacy's right to payment under the Act for medications it dispensed for treatment of Claimant's accepted work injury. Pharmacy contends that the Hearing Office erred in relying upon the C&R Agreement, which was employed improperly to deprive Pharmacy of due process of law and to usurp the procedures in the Act for resolving fee disputes. Finally, Pharmacy argues that Employer waived its ability to use the 2016 C&R Agreement as the basis of its motion to dismiss.[6]

---

[5] ***HN1***[] Our review in medical fee review cases determines whether constitutional rights were violated, whether an error of law was committed, or whether the necessary findings of fact were supported by substantial evidence. *Pittsburgh Mercy Health System v. Bureau of Workers' Compensation, Fee Review Hearing Office (U.S. Steel Corp.)*, 980 A.2d 181, 184 n.4 (Pa. Cmwlth. 2009). Regarding questions of law, our scope of review is plenary and our standard of review is *de novo*. *Sedgwick Claims Management Services, Inc., v. Bureau of Workers' Compensation, Fee Review Hearing Office (Piszel and Bucks County Pain Center)*, 185 A.3d 429, 433 n.2 (Pa. Cmwlth. 2018).

[6] Pharmacy asserts waiver because Employer's request for a hearing to contest the fee review determination did not cite the 2016 C&R Agreement. It did not yet exist. Because we decide the appeal on other grounds, we do not address Pharmacy's waiver claim.

Applicable Law

HN2[] The Act requires employers to make prompt payment on provider invoices for reasonable and necessary medical treatment of a claimant's work injury. The Act also establishes specific procedures for resolving disputes between a provider and an employer about whether the treatment that generated the invoice actually meets that standard. Section 301(f.1)(5) states:

> The employer or insurer shall make payment and providers shall submit bills and records in accordance with the provisions of this section. *All payments to providers for treatment provided pursuant to this act shall be made within thirty (30) days of receipt of such bills and records unless the employer or insurer disputes the reasonableness* ***[**9]*** *or necessity of the treatment provided pursuant to paragraph (6).* The nonpayment to providers within thirty (30) days for treatment for which a bill and records have been submitted shall only apply to that particular treatment or portion thereof in dispute; payment must be made timely for any treatment or portion thereof not in dispute. *A provider who has submitted the reports and bills required by this section and who disputes the amount or timeliness of the payment from the employer or insurer shall file an application for fee review* with the department no more than thirty (30) days following notification of a disputed treatment or ninety (90) days following the original billing date of treatment. If the insurer disputes the reasonableness and necessity of the **[*309]** treatment pursuant to paragraph (6), the period for filing an application for fee review shall be tolled as long as the insurer has the right to suspend payment to the provider pursuant to the provisions of this paragraph. Within thirty (30) days of the filing of such an application, the department shall render an administrative decision.

77 P.S. §531(5) (emphasis added). "Paragraph 6" states, in relevant part, as follows:

> *[D]isputes as to reasonableness or necessity* ***[**10]*** *of treatment by a health care provider shall be resolved in accordance with the following provisions*:
>
> (i) The reasonableness or necessity of all treatment provided by a health care provider under this act may be subject to prospective, concurrent or retrospective utilization review at the request of an employe, employer or insurer. The department shall authorize utilization review organizations to perform utilization review under this act. Utilization review of all treatment rendered by a health care provider shall be performed by a provider licensed

> in the same profession and having the same or similar specialty as that of the provider of the treatment under review.

77 P.S. §531(6) (emphasis added).

In sum, ***HN3***[] where an employer challenges a provider's treatment as neither reasonable nor necessary, it must seek utilization review pursuant to Section 301(f.1)(6) of the Act. Until the utilization review determination is issued, the employer may "suspend payment to the provider." Section 301(f.1)(5), 77 P.S. §531(5). Where a provider does not receive payment within 30 days (and payment has not been stayed by an employer's utilization review request), it has recourse. The provider may file a fee review petition under Section 301(f.1)(5) of the Act, which gives that provider a **[**11]** right to prompt payment for reasonable and necessary medical treatment of a claimant's accepted work injury.

Notably, a fee review proceeding cannot be used to establish that a claimant has a work-related injury for which the employer has liability. As this Court has explained:

> ***HN4***[] the fee review process *presupposes* that liability has been established, either by voluntary acceptance by the employer or a determination by a WCJ. Neither the Act nor the medical cost containment regulations provide any authority for a fee review officer to decide the issue of liability in a fee review proceeding. The Department's regulations, at 34 Pa.Code § 127.255(1), state that an application for fee review filed by a provider is premature and will be returned if "[t]he insurer denies liability for the alleged work injury." The issue for the fee review officer is the "amount and timeliness of the payment made by an insurer." 34 Pa.Code § 127.251.

Nickel v. Workers' Compensation Appeal Board (Agway Agronomy), 959 A.2d 498, 503 (Pa. Cmwlth. 2008) (emphasis added). Any dispute about whether a claimant has a work injury, or the scope of that injury, must be litigated in accordance with the procedures of the Act for a claim petition proceeding. *See* Inglis House v. Workmen's Compensation Appeal Bd. (Reedy), 535 Pa. 135, 634 A.2d 592, 595 (Pa. 1993) ("[I]n a claim proceeding, the employee bears the burden of establishing a right to compensation and of **[**12]** proving all necessary elements to support an award").

Pharmacy argues it has a right to payment under Section 301(f.1)(5) of the Act, which is a right protected by due process **[*310]** of law.[7] It contends that Employer's collusive 2016 C&R Agreement was designed solely to nullify the Medical Fee Review Section's determination and to bypass the fee review procedures set forth in Section 301(f.1)(5) of the Act. Employer responds that Section 449(a) of the Act[8] provides that "[n]othing in this act shall impair the right of the parties interested to compromise and release, subject to the provisions herein contained, any and all liability which is claimed to exist under this act on account of injury or death." 77 P.S. §1000.5(a). Employer maintains that the 2016 C&R Agreement was consistent with Section 449(a) of the Act and relieved it of liability to pay Pharmacy's invoice as directed by the Medical Fee Review Section.

The central question in this appeal is whether a C&R agreement can **[**13]** be used to set aside a fee review determination that an employer owes reimbursement to a provider for a particular course of treatment.

Analysis

On May 10, 2016, Employer denied payment of Pharmacy's April 19, 2016, bill in its entirety "based on utilization review." R.R. 14a. As noted by the Hearing Officer, Employer "attacked" the 2015 utilization review determination that the compound cream was medically necessary, but it did not appeal that determination in accordance with the provisions of the Act. Hearing Office Adjudication at 4, n.3. Nor did Employer seek a utilization review of the 2016 prescription that was dispensed by Pharmacy or allege that Claimant's condition changed since 2015. *Id.* at 3, n.2. Employer's refusal to pay Pharmacy's 2016 invoice violated the Act and the Department's implementing regulation.

First, if Employer wanted to suspend its obligation to pay Pharmacy's 2016 invoice within 30 days, it had to file a new utilization review application in accordance with Section 301(f.1)(6) of the Act. It did not do so and, thus, it lacked a lawful basis not to pay Pharmacy promptly in accordance with Section 301(f.1)(5) of the Act.

---

[7] The Due Process Clause of the Fourteenth Amendment states as follows:

> No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

U.S. CONST. amend. XIV, §1. The Pennsylvania Constitution also provides this protection. PA. CONST. art. I, §9.

[8] Added by the Act of June 24, P.L. 350, 77 P.S. §1000.5(a).

Second, the Department's regulation provides that where a "bill is denied entirely, insurers **[**14]** shall provide a written explanation of the denial." 34 Pa. Code §127.209. Employer gave a false reason, *i.e.*, that Pharmacy's invoice was denied on the basis of "utilization review." This was contrary to the 2015 determination of the utilization review organization that the compound cream was reasonable and necessary to treat Claimant's neuropathy. Giving a false reason, even one in writing, is not the "explanation" required by the regulation.

Pharmacy properly responded to Employer's refusal to pay by submitting a timely application for fee review under Section 306(f.1)(5) of the Act. The Medical Fee Review Section promptly granted Pharmacy's application, calculating the amount owed to be $6,644.30 and 10% interest on the unpaid sum "calculated from the date payment on each bill was due." R.R. 25a.

[*311] Employer relies upon paragraph 10 of the 2016 C&R Agreement that purported to dissolve Employer's liability for any past, present and future compound creams. However, paragraph 10 also states that Employer "shall pay reasonable, necessary and related medical expenses incurred *before* the hearing date [on the 2016 C&R Agreement]." R.R. 59a (emphasis added). This includes the compound cream issued to Claimant in 2016, which was specifically **[**15]** determined by the Medical Fee Review Section to be reasonable and necessary in 2015 *before* the hearing on the 2016 C&R Agreement. In short, paragraph 10 obligated Employer to pay for the "reasonable and necessary" compound creams dispensed by Pharmacy in 2016 because the expense therefor had already been "incurred."[9] *Id.*

HN5[] A valid C&R agreement is "binding upon the parties." *Department of Labor & Industry, Bureau of Workers' Compensation v. Workers' Compensation Appeal Board (US Food Service)*, 932 A.2d 309, 314 (Pa. Cmwlth. 2007). However, Pharmacy was not a party to the 2016 C&R Agreement. Accordingly, Employer's reliance upon Section 449(a) of the Act is misplaced. ***HN6***[] The scope of Section 449(a) is limited to "parties interested" that wish to "compromise and release ... any and all liability" under the Act. 77 P.S. §1000.5(a). This does not include the provider.[10]

Further, as a matter of due process, Pharmacy cannot be deprived of its rights under the Act except in accordance with due process of law.

In *In re Upset Sale*, 505 Pa. 327, 479 A.2d 940 (Pa. 1984), the Pennsylvania Supreme Court affirmed that the U.S. Constitution requires notice and an opportunity to be heard before property or property rights may be taken, particularly when the process is part of a state regulatory scheme. The Court stated:

> ***HN7***[] The Due Process Clause of the Fourteenth Amendment to the Federal Constitution requires at a minimum that the deprivation of life, liberty or property by adjudication must be preceded by notice and opportunity for hearing **[**16]** appropriate to the nature of the case. The United States Supreme Court beginning with *Mullane v. Central Hanover Bank and Trust Co.*, 339 U.S. 306, 94 L.Ed. 865, 70 S.Ct. 652 (1950), has invoked the Due Process Clause and required states to make efforts to provide actual notice to all parties whose interests are affected by proceedings before a tribunal.

Id. at 943.

In *Mullane v. Central Hanover Bank and Trust Co.*, 339 U.S. 306, 70 S. Ct. 652, 94 L. Ed. 865 (1950), the U.S. Supreme Court explained that:

> ***HN8***[] An elementary and fundamental requirement of due process in any proceeding which is to be accorded finality is notice reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections.

The Court further held that the "notice must be of such nature as reasonably to convey the required information, and it **[*312]** must afford a reasonable time for those interested to make their appearance." *Id.* (internal citations omitted).

In *Baksalary v. Smith*, 579 F. Supp. 218 (E.D. Pa. 1984), the U.S. District Court held that the "automatic supersedeas" provision of the Act, which allowed an employer to suspend a claimant's disability compensation without a prior hearing, was unconstitutional under the Due Process Clause of the Fourteenth Amendment. That the claimant could eventually have his compensation reinstated was not sufficient to satisfy due process because the claimant "had no avenue to contest [the suspension's] **[**17]** application." *Id.* at 221-22.

HN9[] The Act's utilization review and fee review

---

[9] Claimant has no liability to Pharmacy. Section 306(f.1)(7) provides: "[a] provider shall not hold an employe liable for costs related to care or service rendered in connection with a compensable injury under this act. A provider shall not bill or otherwise attempt to recover from the employe the difference between the provider's charge and the amount paid by the employer or the insurer." 77 P.S. §531(7).

[10] The other provisions of Section 449 speak to the rights of the "employer or insurer" and "the claimant" (or his dependents or survivors). 77 P.S. §1000.5.

procedures have been designed to comport with due process. They give both the employer and provider an opportunity to be heard on the factual question of whether a provider's treatment was reasonable and necessary and, thus, required to be paid for by the employer. A C&R agreement, to which a provider is not a party, cannot be used to deprive a provider of the review procedures and excuse the employer from paying the provider. To do so would violate the Act and due process. *Baksalary*, 579 F. Supp. at 221-22.

Also instructive is *Gingerich v. Workers' Compensation Appeal Board* (*U.S. Filter*), 825 A.2d 788 (Pa. Cmwlth. 2003). In that case, a claimant and her tort counsel entered into a C&R agreement with the employer that, *inter alia*, allowed the claimant to retain the tort claim award and released the employer from future payment of her compensation counsel's fees. This Court held that neither the claimant nor her employer could deprive her compensation counsel of these fees via a C&R Agreement. Neither was "the person with the claim." *Id.* at 791. Likewise, here, Claimant had no authority to "release" Employer from its liability to Pharmacy because Claimant was not "the person with the claim." Nor could Employer release itself from its liability to Pharmacy established **[**18]** by the Medical Fee Review Section. ***HN10***[] The parties to a C&R agreement can bind each other, but they cannot release themselves from liability to a person who is not a party to the C&R agreement and who has been given neither notice nor opportunity to be heard on the C&R Agreement.

Conclusion

The 2016 C&R Agreement holds Employer liable for all "reasonable, necessary and related medical expenses incurred before the date of the [October 25, 2016] hearing." 2016 C&R Agreement, ¶10; R.R. 59a. The Addendum to Paragraph 10 purports to exclude Pharmacy's 2016 invoice from its reach for the stated reason that Dr. Bundy has a financial interest in Pharmacy. However, there is no evidence that Dr. Bundy has a financial interest in Pharmacy, and there has not been a legal determination that this financial relationship, if it exists, violates the Act. The stated "belief" of the parties in the 2016 C&R Agreement on this legal question is meaningless.

The 2016 C&R Agreement requires Employer to pay for all reasonable and necessary medical expenses incurred prior to hearing, and it is for the utilization review organization to decide whether the compound cream treatment was reasonable and necessary. It did **[**19]** so in 2015, and Employer never challenged that determination. A C&R Agreement cannot be employed to avoid the procedures in the Act for challenging a provider's invoice or a fee review determination that the invoice must be paid. To hold otherwise would eviscerate Section 301(f.1)(5) and (6) of the Act and violate the due process of law guaranteed to providers.

[*313] Accordingly, we vacate the adjudication of the Hearing Office that the 2016 C&R Agreement eliminated Employer's liability to Pharmacy. We remand to the Bureau for a decision on the merits of Employer's request for a hearing to contest the fee review determination of July 25, 2016, in favor of Pharmacy.

MARY HANNAH LEAVITT, President Judge

ORDER

AND NOW, this 7th day of August, 2018, the order of the Bureau of Workers' Compensation, Fee Review Hearing Office of October 3, 2017, is VACATED and the matter is REMANDED for a decision on the merits of the request for a hearing to contest the fee review determination filed by National Fire Insurance Company of Hartford, in accordance with the attached opinion.

Jurisdiction relinquished.

MARY HANNAH LEAVITT, President Judge

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

Federated Insurance Company, Petitioner	:	
v.	:	No. 115 C.D. 2023
	:	Argued: November 8, 2023
Summit Pharmacy (Bureau of Workers' Compensation Fee Review Hearing Office), Respondent	:	

BEFORE: **HONORABLE RENÉE COHN JUBELIRER,** President Judge
HONORABLE PATRICIA A. McCULLOUGH, Judge
HONORABLE ANNE E. COVEY, Judge
HONORABLE MICHAEL H. WOJCIK, Judge
HONORABLE CHRISTINE FIZZANO CANNON, Judge
HONORABLE LORI A. DUMAS, Judge
HONORABLE STACY WALLACE, Judge

OPINION BY
PRESIDENT JUDGE COHN JUBELIRER **FILED: January 2, 2024**

Federated Insurance Company (Petitioner) petitions for review of the Order of the Bureau of Workers' Compensation (Bureau) Fee Review Hearing Office in which a Bureau Hearing Officer ordered Petitioner to pay Summit Pharmacy (Respondent) approximately $72,500 to reimburse Respondent for generic drugs provided to Karen Link (Claimant) for her work-related injuries. In ordering reimbursement in this amount, the Hearing Officer used the "Red Book" values for the prescriptions at issue, which the Bureau adopted as the average wholesale price (AWP) to be used in resolving payment disputes over pharmaceuticals. It is the Bureau's adoption and use of the Red Book values to resolve payment disputes that is at issue in this appeal.

The Red Book is a privately published, electronic compendium of pharmaceutical and over-the-counter drug "AWPs" available online. (Reproduced Record (R.R.) at 792a); *Commonwealth v. TAP Pharm. Prods., Inc.*, 36 A.3d 1112, 1130 (Pa. Cmwlth. 2011) (*TAP*), *vacated on other grounds*, 94 A.3d 364 (Pa. 2014). It is updated regularly to reflect changes in prices. (R.R. at 818a.) At the time relevant to this matter, the publisher of the Red Book was IBM Health Watson, although the publisher can, and does, change. (*Id.* at 843a-44a); *see Indem. Ins. Co. of N. Am. v. Bureau of Workers' Comp. Fee Rev. Hearing Off. (Insight Pharm.)*, 245 A.3d 1158, 1162 (Pa. Cmwlth. 2021) (*Indemnity Insurance*) (reflecting that the publisher of the Red Book then was Truven Health Analytics). In its statement of policy, IBM Health Watson indicates that the AWP it publishes "is, in most cases, the manufacturer's suggested AWP and does not reflect the actual AWP charged by a wholesaler," that the values used in the Red Book are reported to it by the manufacturer, and that IBM Health Watson does not independently analyze the data to ascertain the amounts paid by providers, such as pharmacies, to wholesalers. (R.R. at 843a.) Red Book values have been described as being similar to the manufacturer's suggested retail price or "sticker price" of a car. (*Id.* at 836a.)

Petitioner argues the Bureau's adoption and use of Red Book values in payment disputes is inconsistent with Section 306(f.1)(3)(vi)(A) of the Workers' Compensation Act (Act),[1] which limits the reimbursement of pharmaceuticals to "one hundred ten per centum of the . . . []AWP[] of the product." 77 P.S. § 531(3)(vi)(A). Petitioner maintains Red Book values do not, and cannot, reflect the AWP, as defined by its plain meaning, because of how those values are derived, and, therefore, the Bureau exceeded its statutory authority by adopting the Red

[1] Act of June 2, 1915, P.L. 736, *as amended*, 77 P.S. § 531(3)(vi)(A).

Book. Petitioner further asserts that, if using the Red Book is not inconsistent with the Act, its ongoing adoption by the Bureau represents an improper delegation of legislative authority to a private entity under *Protz v. Workers' Compensation Appeal Board (Derry Area School District)*, 161 A.3d 827 (Pa. 2017). Respondent, in turn, maintains that AWP is a term of art used within the pharmaceutical industry and, as its expert witness credibly testified, the Red Book is an accepted source of AWP within that industry. It also argues there is no unlawful delegation to a private entity in violation of *Protz*, an argument that has previously been rejected by this Court. Upon review of the statutory language, case law, and record, we agree with Petitioner that the Red Book values do not reflect AWP as required by the Act. Accordingly, we reverse the Hearing Officer's Order, and remand the matter for further proceedings consistent with the following opinion.[2] Additionally, we direct the Bureau to promptly identify and publish in the *Pennsylvania Bulletin* a different nationally recognized schedule to be used to determine the AWP for purposes of resolving payment disputes for pharmaceuticals.

I. BACKGROUND

This Court has previously set forth the relevant factual and procedural background in a memorandum opinion, granting Petitioner's request for supersedeas from the Hearing Officer's Order, as follows:

> Petitioner is the [workers' compensation (]WC[)] insurer for the employer of . . . []Claimant[], who sustained a work injury in 2010 and is entitled to WC benefits under the . . . Act . . . .[] (Hearing Officer Decision, Finding[s] of Fact (FOF) ¶¶ 3-4.) Respondent is an Arizona-

[2] Because we agree with Petitioner on this issue, we do not address Petitioner's constitutional arguments. *See Wertz v. Chapman Township*, 709 A.2d 428, 431 (Pa. Cmwlth. 1998) (stating "it is a cardinal principle of jurisprudence that where decision can be had on other than constitutional grounds, the court should decide the case on the nonconstitutional grounds").

based online pharmacy that provides Claimant with her prescription medication for her work injury. (*Id.* ¶ 4.) Beginning in 2019, Respondent submitted to Petitioner, and Petitioner paid to Respondent, bills for drugs dispensed to Claimant totaling approximately $109,000, which were billed at a wholesale price proposed by Respondent. (Application [For Supersedeas] (Appl.), Attachment C.) In 2021, Petitioner determined that Respondent's billed pricing was far above the actual . . . []AWP[] of the drugs, as reported in the National Average Drug Acquisition Cost Index (NADAC). (Appl. ¶ 4.) Thus, for the bills Respondent submitted between April 15, 2021, and September 8, 2022, totaling about $74,011.81, Petitioner adjusted its payments to be 110% of AWP as determined using NADAC, totaling $1,511.93. (FOF ¶ 4; Appl. ¶ 4.) This left $72,499.88 in disputed, unpaid bills, plus interest. (FOF ¶¶ 4, 7.)

Respondent filed applications for fee review. (*Id.* ¶ 5.) The Bureau's Fee Review Section issued determinations applying a different cost index, known as "Red Book," based upon the cost containment regulations promulgated under the Act. *See* 34 Pa. Code §§ 127.1-127.755; *see also* Section 306(f.1)(3)(vi)(A) of the Act, 77 P.S. § 531(3)(vi)(A) (limiting reimbursement for drugs and professional pharmaceutical services to "one hundred ten per centum of the . . . []AWP[] of the product, calculated on a per unit basis, as of the date of dispensing"). The determinations ordered Petitioner to pay the disputed $72,500. Petitioner filed 15 requests for fee review hearings ([1] for each separate bill), and Respondent filed 3 such requests, which were consolidated before the Hearing Officer for hearings over 6 days. (FOF ¶¶ 6-7.)

At the hearing, Petitioner bore the burden of proving, by a preponderance of the evidence, that it had properly reimbursed Respondent. *See* 34 Pa. Code § 127.259(f); *Liberty Mut. Ins. Co. v. Bureau of Workers' Comp., Fee Rev. Hearing Off. (Kepko)*, 37 A.3d 1264, 1269 n.11 (Pa. Cmwlth. 2012). To do so, it sought to show that Red Book pricing is artificially inflated and does not represent actual AWP, which is what the Act requires be used to determine pricing. Petitioner presented the expert testimony of Fred Selck, Ph.D., a healthcare-market economic consultant. (Hearing Officer Decision, FOF ¶¶ 16-20 (summarizing Selck's testimony); . . . R.R.[] at 35a-156a (notes of testimony).)[3] Selck explained that a drug's AWP is the average of the amounts that all purchasers pay to purchase that drug from a wholesaler. (R.R. at 99a [(emphasis omitted)].) Selck contrasted that meaning of AWP with Red Book, which is "just a

number that the . . . manufacturer provides," and the manufacturer does not "do[] any kind of analysis to understand what providers are paying for their product" when determining the Red Book price. (*Id.* at 101a.) Red Book provides the list price that manufacturers use as a starting point in negotiations with wholesalers or insurers; it has "nothing to do" with the actual acquisition cost of the drug at wholesale. (*Id.*)

> 3. Respondent objected to Selck's qualification as an expert. Selck admitted he had never worked as a pharmacist, was not familiar with the Act or the cost containment regulations, and has never testified as an expert in Pennsylvania about AWP. (R.R. at 87a-92a.) He also admitted he had never reviewed any of the Bureau's annual statements specifying a benchmark for AWP, which are published annually in the Pennsylvania Bulletin pursuant to the cost containment regulations. (*Id.*); *see* 34 Pa. Code § 127.131(b). The Hearing Officer allowed Selck to testify as a healthcare economist and not as a legal expert. (R.R. at 96a.)

Selck explained that, unlike Red Book, NADAC AWP is determined through a monthly survey of pharmacies' actual acquisition or "invoice" prices paid for a drug, and then by calculating an average of the responding pharmacies' reported invoice prices. (*Id.* at 104a-06a.) In most cases the invoice price used in NADAC is paid to a wholesaler to acquire the drug, but in some cases the invoice price is paid directly to a manufacturer. (*Id.* at 108a.) Though manufacturers state a suggested retail price—which is approximated by Red Book—they routinely discount that price heavily in order to compete for sales to pharmacies. (*Id.* at 111a-12a.) NADAC reflects those discounted, actual wholesale prices. (*Id.* at 112a.) NADAC is used by several state Medicaid agencies, and increasingly by commercial insurers, to calculate reimbursement rates. (*Id.* at 108a-09a.) Generally, "everybody understands . . . within the generic [market] that the . . . Red Book AWP . . . nobody pays that price." (*Id.* at 112a.) Respondent's submitted prices reflected Red Book prices plus 10%, and "were far in excess of . . [.] the actual acquisition cost[]" reflected in NADAC. (*Id.* at 118a.)

On cross-examination, Selck acknowledged there are national cost indices other than NADAC, but reiterated that NADAC is by far the most reliable for determining actual [AWPs] paid. (*Id.* at 133a.) There are other cost indices that, like Red Book, measure list prices provided

by manufacturers rather than actual wholesale prices paid by pharmacies. (*Id.* at 135a-38a.) Selck also added that, when using NADAC price to calculate AWP for purposes of reimbursement, he added a 10% markup to allow a small profit margin to the pharmacy for making the transactions in question. (*Id.* at 142a.)

. . . .

In rebuttal, Respondent presented P.J. Ortmann, a consultant and licensed Pennsylvania pharmacist, as an expert on pharmaceutical pricing. (FOF ¶ 26; R.R. at 792a.) Ortmann agreed that NADAC reflects a drug's acquisition price, or "[t]he cost [at which] the pharmacy can buy [a] drug from a wholesaler." (*Id.* at 804a.) He explained, however, that pharmacies cannot profitably be compensated based on wholesale acquisition cost, even if the reimbursement includes a 10% markup, because the acquisition costs are extremely low. (*Id.* at 802a-03a.) For example, for a drug with a $10 NADAC acquisition cost, reimbursement at 110% of the NADAC cost would leave the pharmacy with only $1 to cover its overhead cost of filling the prescription. The average cost to fill a prescription is $12.50, so the pharmacy would lose money on each transaction. (*Id.*) Thus, pharmacies are typically reimbursed based on the higher Red Book AWP in order to make it profitable to dispense drugs to recipients of WC benefits. (*Id.* at 806a-09a.) Red Book AWP often differs dramatically from NADAC acquisition prices, especially for generic drugs. (*Id.* at 808[a]-09a.) For example, the Red Book AWP for a bottle of generic Prozac is approximately $2,000, but the NADAC acquisition price (which the pharmacy pays at wholesale) is $9. (*Id.* at 809a.)

On cross-examination, Ortmann again distinguished between Red Book, which he stated provides an AWP, and NADAC, which measures average acquisition cost. (*Id.* at 815a.) He disagreed that NADAC could be described as reporting an [AWP]. (*Id.* at 815a, 822a.) He agreed that Red Book states a wholesale price suggested by manufacturers and "does not necessarily reflect the actual wholesale price charged by a wholesaler." (*Id.* at 817a.) Ortmann further agreed that pharmacies do not rely on Red Book prices when purchasing drugs at wholesale—Red [B]ook is used for reimbursement only. (*Id.* at 820a.) When asked about his earlier testimony about the disparity between a $2,000 Red Book price and a $9 wholesale acquisition price for a bottle of Prozac, Ortmann stated:

> The reason that comes into play is the large [prescription benefit managers (]PBMs[)] offer the insurance company 85[%] discounts to make it look like they're getting a significant savings when, in fact, that's still much more than the drug actually costs.
>
> > Q. And just to be clear for the record, PBM is [a] prescription benefit manager?
> >
> > A. That is correct.
> >
> > Q. Okay.
> >
> > A. They're the companies that actually process the prescription claims, and they are the go-go [sic] between the insurance company, the pharmacy[,] and the patient.
> >
> > Q. Do you have any documentation as to how much [Respondent] has paid for any of these medications in question, Doctor?
> >
> > A. I have no idea.

(*Id.* at 830a-31a.) On redirect, Ortmann indicated that the phrase "average wholesale price" is a term of art in the pharmaceutical industry. (*Id.* at 836a.) In his view, AWP is not a mathematical average of actual prices paid, but rather a manufacturer's suggested price that is used as a reference in benefit negotiations between pharmacies, PBMs, and third parties. (*Id.*)

In the January 11, 2023 Decision, the Hearing Officer affirmed the Bureau's fee review determinations. He concluded that Selck's credentials did not qualify him as an expert, and even if they did, he found Selck's testimony "wholly unpersuasive, inapposite[, and] obfuscatious." (FOF ¶¶ 17, 22.) The Hearing Officer found that, where the testimony of Ortmann and Selck conflicted, Ortmann's testimony was more credible and accepted over Selck's testimony. (*Id.* ¶ 25.) He concluded that Petitioner failed to meet its burden to show that its payment of 110% of NADAC price had properly reimbursed Respondent under the Act and the cost containment regulations. (*Id.* ¶ 28.) In so concluding, the Hearing Officer distinguished cases cited by Petitioner where courts have opined in other contexts that Red Book

> pricing is inflated or fictitious. (Hearing Officer Decision at 15 (distinguishing . . . *TAP* . . . , 36 A.3d 1112 . . . (Commonwealth action against pharmaceutical manufacturers alleging the Red Book AWPs were inflated and violated consumer protection laws) . . . ; *In re Pharm. Indus. Average Wholesale Price Litig.*, 491 F. Supp. 2d 20 (D. Mass. 2007) (*MDL 2007*) (class action against pharmaceutical manufacturers' inflating prescription drug costs), *aff'd*, 582 F.3d 156 (1st Cir. 2009), *cert. dismissed sub nom. AstraZeneca Pharms. LP v. Blue Cross Blue Shield of Mass*[.], 561 U.S. 1056 (2010).) He also disagreed that a recent decision of this Court allowed an insurer "to ignore [the] Red Book" or required or supported the use of NADAC, and, in fact, rejected an argument similar to Petitioner's here. (*Id.* (discussing *Indem. Ins*. . . . , 245 A.3d [at] 1168 . . .).)

Federated Ins. Co. v. Summit Pharm. (Bureau of Workers' Comp. Fee Rev. Hearing Off.) (Pa. Cmwlth., No. 115 C.D. 2023, filed June 13, 2023) (single-judge op.) (Cohn-Jubelirer, P.J.), slip op. at 2-7 (emphasis omitted) (some alterations added). Accordingly, the Hearing Officer directed Petitioner to reimburse Respondent the amounts set forth in the fee review determinations using the Red Book values. Petitioner now asks this Court to review that Order.[3]

II. DISCUSSION

A. Parties' Arguments

Petitioner argues the Bureau's continued adoption of the Red Book to provide default values in payment disputes, and the Hearing Officer's application of those values here, are inconsistent with Section 306(f.1)(3)(vi)(A)'s language, which utilizes the AWP of a drug to determine the maximum reimbursement amount. According to Petitioner, while the Act provides that reimbursement is to be made at 110% of the AWP, it does not define AWP, which, in Petitioner's view, should be

[3] "This Court's review of the Hearing Office's adjudication considers whether necessary findings of fact are supported by substantial evidence, whether constitutional rights were violated, and whether the Hearing Office erred as a matter of law." *Indem. Ins.*, 245 A.3d at 1163 n.5.

defined by the plain and common usage of "average" and "wholesale price," not as a term of art. Petitioner maintains AWP means "actual" AWP, or an average of the AWPs pharmacies throughout the country pay for the prescription drugs, they then resell to their customers, a definition Petitioner contends is supported by our decision in *Indemnity Insurance*. Petitioner argues the Red Book, adopted as the default AWP by the Bureau, cannot be used to calculate AWP because it is not an average of actual acquisition costs, or the prices paid by any pharmacies to manufacturers/wholesalers. Instead, Petitioner asserts, this Court in *Indemnity Insurance* and *TAP*, and federal district courts in *MDL 2007*, recognized that the Red Book is an entirely fictitious and inflated index made up of a manufacturer's "suggested" AWP that far exceeds, as both Ortmann and Selck testified, the amounts actually paid by any pharmacy. Petitioner notes that Medicare, along with other state legislatures, no longer use the Red Book for this reason. In contrast to the fictitious numbers used in the Red Book, Petitioner argues, the NADAC reflects the AWP paid by pharmacies and satisfies the factors identified in *Indemnity Insurance* as being the qualities of an AWP, facts that were unrebutted by Respondent's evidence. And, Petitioner contends, the use of the NADAC would significantly decrease costs, which furthers the purpose of the cost containment amendments that added the limiting language to Section 306(f.1)(3)(vi)(A). Finally, Petitioner argues the issue is not whether pharmacies can make a profit, on which the Hearing Officer appeared to focus, but whether the Bureau is complying with the Act's language, and it is not.

Respondent argues the General Assembly used "average wholesale price" in Section 306(f.1)(3)(vi)(A), 77 P.S. § 531(3)(vi)(A), not "actual wholesale price" or "actual average wholesale price," and the Court may not substitute language that it

might prefer for that used by the General Assembly. *Keystone Rx LLC v. Bureau of Workers' Comp. Fee Rev. Hearing Off. (Compservs. Inc./Amerihealth Case Servs.)*, 265 A.3d 322, 330-31 (Pa. 2021). Respondent asserts the General Assembly's use of AWP in Section 306(f.1)(3)(vi)(A), as interpreted in the Bureau's regulations to include the Red Book's values, is consistent with how the phrase is used in the pharmaceutical industry, as well as within other Pennsylvania statutes and regulations. (Respondent's Brief at 31-33 n.9, 40-41 (citing various statutory and regulatory provisions that use "average wholesale price" or similar language).) Because the Bureau's regulation is consistent with the Act's plain language, Respondent argues the Court should not substitute its judgment for that of the Bureau, which the Bureau has exercised since it first promulgated regulations on this topic in November 1995. According to Respondent, numerous stakeholders were involved in that process, and the Bureau's adoption of the Red Book occurred at that time. Respondent observes that the regulation identifying the Red Book is repromulgated annually in a process subject to review and objection by stakeholders, but none have ever been made by Petitioner.

Respondent contends Petitioner's other arguments are likewise without merit, pointing in particular to the fact that the Hearing Officer credited Ortmann's testimony and rejected Selck's testimony. Respondent maintains the credited testimony supports the continued use of the Red Book, rather than the NADAC plus 110%, as suggested by Selck, because the latter standard has never been adopted and does not account for the fact that Medicare (and every state that bases reimbursement on the NADAC) allows for the charge of "dispensing fees" to cover pharmacy costs. Respondent argues *Indemnity Insurance* did not authorize the abandonment of the Red Book in all instances; it held that alternative evidence as to a more accurate

AWP could be introduced but did not require that the alternative evidence be credited. Respondent further argues *TAP* should not be relied upon to determine what AWP means under the Act because *TAP* was not a WC case, did not examine the Act's language, and was decided before the Supreme Court's admonition in *Keystone Rx LLC* that this Court should not rewrite the Act where it believes the Act should have been drafted differently.

B. The Statutory and Regulatory Language

The parties have placed the meaning of "AWP" in Section 306(f.1)(3)(vi)(A), and the regulations promulgated to implement that provision, before the Court. Section 306(f.1)(3)(vi)(A) relates, in part, to "medical services and supplies," and provides, in relevant part: "The reimbursement for drugs and professional pharmaceutical services shall be limited to one hundred ten per centum of the . . . []AWP[] of the product, calculated on a per unit basis, as of the date of dispensing." 77 P.S. § 531(3)(vi)(A). This subsection was added to the Act, via amendment, by Section 8 of the Act of July 2, 1993, P.L. 190, No. 44 (Act 44), which also renumbered the section as Section 306(f.1) of the Act. It was subsequently amended to its current language by Section 1 of the Act of October 27, 2014, P.L. 2894, No. 184 (Act 184).[4] Neither Act 44, Act 184, nor the Act more broadly, define "AWP." 77 P.S. § 531(3)(vi)(A).

The Bureau promulgated cost containment regulations pursuant to, *inter alia*, Act 44, and those regulations provide:

> **§ 127.131. Payments for prescription drugs and pharmaceuticals--generally.**

[4] Relevantly, Act 184 added "calculated on a per unit basis, as of the date of dispensing" after "average wholesale price (AWP) of the product." 77 P.S. § 531(3)(vi)(A).

> (a) Payments for prescription drugs and professional pharmaceutical services shall be limited to 110% of the . . . []AWP[] of the product.
>
> (b) Pharmacists and insurers may reach agreements on which Nationally recognized schedule shall be used to define the AWP of prescription drugs. The Bureau in resolving payment disputes, may use any of the Nationally recognized schedules to determine the AWP of prescription drugs. The Bureau will provide information by an annual notice in the *Pennsylvania Bulletin* as to which of the Nationally recognized schedules it is using to determine the AWP of prescription drugs.
>
> (c) Pharmacists may not bill, or otherwise hold the employe liable, for the difference between the actual charge for the prescription drugs and pharmaceutical services and 110% of the AWP of the product.

34 Pa. Code § 127.131. As described in subsection (b), the Bureau publishes annual notices in the Pennsylvania Bulletin designating the Red Book as the schedule to use in determining the AWP of prescription drugs. *See*, *e.g.*, 52 Pa.B. 7792 (Dec. 17, 2022); 46 Pa.B. 3389 (June 25, 2016); 40 Pa.B. 5025 (Aug. 28, 2010). The version of such notice in effect at the time the parties filed the fee review applications here provided that "[u]nder 34 Pa. Code § 127.131(b) (relating to payments for prescription drugs and pharmaceuticals--generally), the . . . Bureau . . . [] gives notice that it utilizes the *IBM Micromedex Red Book* to determine the average wholesale price of prescription drugs." 51 Pa.B. 7804 (Dec. 11, 2021).

C. Analysis

The arguments currently presented to the Court raise an issue of statutory construction regarding the meaning of AWP, which forms the basis of the reimbursement scheme of Section 306(f.1)(3)(vi)(A) and the cost containment regulations. Our statutory interpretation is guided by the Statutory Construction Act of 1972 (SCA). 1 Pa.C.S. §§ 1501-1991. Under Section 1921(a) of the SCA, "[t]he

object of all interpretation and construction of statutes is to ascertain and effectuate the intention of the General Assembly." 1 Pa.C.S. § 1921(a). "The clearest indication of legislative intent is generally the plain language of a statute." *Walker v. Eleby*, 842 A.2d 389, 400 (Pa. 2004). "When the words of a statute are clear and free from all ambiguity, the letter of it is not to be disregarded under the pretext of pursuing its spirit." 1 Pa.C.S. § 1921(b). The Court employs statutory construction only if "the words of the statute are not explicit[.]" 1 Pa.C.S. § 1921(c). In doing so, the general rule is that "[w]ords and phrases shall be construed . . . according to their common and approved usage." Section 1903(a) of the SCA, 1 Pa.C.S. § 1903(a); *Walker*, 842 A.2d at 400. However, "technical words and phrases and such others as have acquired a peculiar and appropriate meaning or are defined in this part, shall be construed according to such peculiar and appropriate meaning or definition." Section 1903(a) of the SCA, 1 Pa.C.S. § 1903(a). "[T]he proper interpretation of a statute[] [] is a question of law." *Walker*, 842 A.2d at 392.

We begin by observing that we are **not** starting our review of Section 306(f.1)(3)(iv)(A) on a blank slate. An en banc panel of this Court in *Indemnity Insurance* has already construed the AWP by using its plain meaning, not as a term of art.

In *Indemnity Insurance*, the insurer determined that a WC pharmacy's use of Red Book values on its invoices was excessive and paid a reduced amount, and the pharmacy challenged that reduced payment by filing a fee review application. At the hearing, the insurer offered an affidavit identifying the difference in the retail price, (i.e., the price charged by the pharmacy), and the wholesale price of one of the five ingredients in the compound cream in question, reflecting that the retail price appeared less than the wholesale price, as well as an excerpt from the Red Book

editor's policy stating the book did not contain "the *actual* AWP charged by a wholesaler." *Indem. Ins.*, 245 A.3d at 1161-62 (emphasis in original). Arguing that a pharmacy obviously would not sell drugs at a price lower than the AWP, the insurer maintained that the lower retail price demonstrated that the Red Book AWP did not represent **actual** AWP, but an inflated, fictitious AWP. *See id.* at 1164-65 (summarizing insurer's argument before hearing officer). The hearing officer did not credit the insurer's evidence on the retail price and held that the insurer had not met its burden of showing it properly reimbursed the pharmacy and, therefore, had to reimburse at the Red Book rate. *Id*. at 1162.

Before this Court, the insurer asserted, as Petitioner does here, that the Act requires use of actual AWP for reimbursement, and the Red Book demonstrably does not represent AWP, but fictitious prices. *Id.* at 1163. The insurer also argued that the regulations' use of the Red Book's fictitious pricing, rather than actual AWP, was not consistent with the Act's language. Last, the insurer asserted, based on *Protz*, that there was a violation of the nondelegation doctrine because the General Assembly delegated its legislative authority to a private entity, the Red Book's editor. The Court addressed these arguments in turn.

On the first issue, the Court observed that the hearing officer had rejected the insurer's evidence of retail prices as not credible and that the Court could not consider the extra-record factual allegations contained in its appellate brief. *Id.* at 1164-65. Based on the credibility determination and noting that proper appellate review is confined to the record made before the government unit, the Court rejected the insurer's unsupported assertions that Red Book AWP is "fictitious" based on the contrary retail prices. *Id.* at 1165. With the insurer's evidence rejected as not credible, the Court held the insurer failed to meet its burden of proving that it

properly reimbursed the pharmacy. *Id.*

The Court then considered whether the regulations' use of Red Book violated the Act's requirement that reimbursement be based on AWP, summarizing the history of Section 306(f.1)(3)(vi)(A), as follows:

> The General Assembly did not define the term "[AWP]."
>
> In . . . *TAP* . . . , this Court explained as follows:
>
> > Since the late 1960s, almost every branded prescription drug sold in the United States has an [AWP], which is published in commercial compendia like Red Book, First DataBank, and Medispan. During the period covered by this lawsuit, AWP is provided in a current, digital format for each available branded pharmaceutical, in each dosage and packaging size. The digital format and the constantly updated value are essential for use in computer-dominated reimbursement systems, such as those used by [the Department of Human Services and Department of Aging]. . . .
>
> [36 A.3d] at 1130. While critical of the AWP-based system for drug reimbursement, **this Court explained that the AWP provided an efficient estimate of acquisition costs for pharmaceuticals**. Further, this Court observed:
>
> > The reference to published prices was not intended to modify the accuracy of the average price phrase; rather, the reference to published prices was intended to establish a widely[ ]available third-party source of average prices. Establishing such a source relieves the [Department of Human Services and Department of Aging] of legal mandates to ascertain, by alternative methods, estimated acquisition costs. . . . In short, the reference to published prices does not change the plain meaning of the cost to be ascertained.
>
> *Id*. at 1161 (citing *Commonwealth v. TAP Pharm*[.] *Prod*[*s.*], *Inc.* (Pa. Cmwlth., No. 212 M.D. 2004, filed Oct[.] 14, 2010) (single-judge op.) (Simpson, J.), slip op. at 8) (citation omitted). **In short, the AWP**

> **provides an objective estimate of acquisition costs for pharmaceuticals available through national pricing schedules.**
>
> In 2014, after the extensive *TAP* litigation, the General Assembly amended Section 306(f.1)(3)(vi) of the Act. . . . **The amendment did not define the term "average wholesale price." It did, however, add [the] phrase ["calculated on a per unit basis, as of the date of dispensing" to the end of] Section 306(f.1)(3)(vi)(A)** . . . .

Indem. Ins., 245 A.3d at 1166-67 (some alterations and emphasis added). Thus, in *Indemnity Insurance*, we held that AWP was intended to be an objective estimate of the costs of acquiring drugs derived on a national basis.

The insurer asserted that the best proxy for actual AWP, which it argued was not reported by the Red Book or any other readily available source, was average retail price. The Court rejected this position, holding that "[t]he legislature could have amended Section 306(f.1)(3)(vi)(A) to define 'average wholesale price' to mean 'average retail price,' as suggested by [the i]nsurer. It did not do so." *Id.* at 1167. The Court concluded that the plain meaning of the phrase "average wholesale price" does not contemplate use of an "average **retail** price," which is what the insurer in *Indemnity Insurance* sought to prove and use before the Bureau. *Id.* at 1168 (emphasis added).

In response to Judge Ceisler's concurring and dissenting opinion that agreed with the insurer's "persuasive statutory construction argument that the AWP" denotes the "**actual** average wholesale price, **not** a fictitious AWP,"[5] the majority

[5] Judge Ceisler, joined by Judge McCullough, filed a concurring and dissenting opinion. The minority opinion agreed with the majority regarding the procedural and factual posture: the insurer had failed to meet its burden before the Bureau because it presented evidence of only retail price—it did not attempt to prove actual AWP. The minority dissented, however, from the Court's construction of the phrase "average wholesale price." Citing *TAP* and *In re Pharmaceutical Industry Average Wholesale Price Litigation*, 460 F. Supp. 2d 277, 287 (D. Mass. 2006) (*MDL 2006*), the minority would have held the phrase to be construed according to its plain meaning, not **(Footnote continued on next page…)**

agreed "that [its] task is to construe **'AWP' according to its plain meaning**." *Id.* at 1167 (emphasis added). Relevant to our current inquiry, the majority went on, explaining:

> [t]he majority opinion does just that. First, the legislature dictated the use of the industry AWP, not the AWP charged by a single manufacturer. The AWP is a number derived by averaging the wholesale prices of all manufacturers or wholesalers. The *TAP* litigation developed the "fictitious" moniker for "AWP." Other than conveying a derogatory connotation, this adjective has little meaning. A number calculated from data collected from the market[]place is neither "fictitious" nor "actual." The number is either accurate or inaccurate, but it has no "actual" existence.

Id.

Thus, pursuant to *Indemnity Insurance*, the "plain meaning" of AWP is a price that is an industry average not one that is "charged by a single manufacturer," and "is a number derived by averaging the wholesale prices of all manufacturers or wholesalers." *Id.* Because "in its plain meaning, Section 306(f.1)(3)(vi) requires the use of 'average wholesale price' and not 'average retail price,'" the insurer's attempt to rely on the latter, through "a conclusory affidavit laden with simple math errors," did "violence to the words used by the legislature." *Id.* at 1167-68. However, this did not mean that an insurer could not "produce[] evidence to support a calculation of an AWP **more accurate** than the one authorized by the regulation and listed by the Bureau in the *Pennsylvania Bulletin*," such as "proposing a Nationally recognized schedule other than the one listed by the Bureau in the

---

as a term of art, and the plain meaning was not a "**fictitious**" AWP but the "**actual**" AWP that was tied to prices actually paid by providers. *Indem. Ins.*, 245 A.3d at 1171-72 (Ceisler, J., concurring and dissenting) (emphasis in original). The minority opinion emphasized that the obvious purpose of the Act's cost containment provisions was to prevent inflated drug prices and reasoned that AWP must be read to require "the **actual** average wholesale price" of a drug, "**not** a fictitious AWP" such as Red Book's. *Id.* at 1172-74 (emphasis in original).

Pennsylvania Bulletin when litigating a repricing dispute . . .”; it was just that the insurer in *Indemnity Insurance* had not done so. *Id.* at 1168 (emphasis added).[6]

“Under *stare decisis*, we are bound to follow the decisions of our Court unless overruled by the Supreme Court or where other compelling reasons can be demonstrated.” *Crocker v. Workers’ Comp. Appeal Bd. (Georgia Pac. LLC)*, 225 A.3d 1201, 1210 (Pa. Cmwlth. 2020) (citation omitted). Although Respondent cites Ortmann’s testimony to argue AWP has a technical meaning within the pharmaceutical industry, the meaning of the statutory language is a question of law, not fact. *Walker*, 824 A.2d at 392. And, while Respondent asserts arguments supporting a contrary interpretation, we are not persuaded it has demonstrated compelling reasons, *Crocker*, 225 A.3d at 1210, or “a special justification, over and above the belief that the precedent was wrongly decided,” to reverse this Court’s prior interpretation of AWP by its plain meaning, *Commonwealth v. Alexander*, 243 A.3d 177, 196-97 (Pa. 2020) (quoting *Allen v. Cooper*, 140 S. Ct. 994 (2020)). Accordingly, we are bound by our interpretations in *Indemnity Insurance* and apply them here.

The parties frame the question as whether the Red Book values are “fictitious” or “actual” AWPs, but the question is really whether the Red Book values are “accurate” or “inaccurate” AWPs. *Indem. Ins.*, 245 A.3d at 1167-68. The Bureau’s regulations adopt the Red Book as an AWP to be used in payment disputes. However, an insurer may introduce evidence challenging the “accuracy” of the Red

[6] The *Indemnity Insurance* Court also rejected the insurer’s nondelegation claim based on *Protz*. The Court observed that the regulation does not require the use of any particular nationally recognized schedule of prices or preclude an employer from offering a different schedule to establish an AWP for the pharmaceuticals at issue. *Indem. Ins.*, 245 A.3d at 1169. Instead, the insurer “made no attempt to establish the so-called ‘actual’ AWP” in its effort to reprice the invoice. *Id.* Accordingly, the Court found that the insurer had no basis for its constitutional claim.

Book pricing for a particular drug's AWP. *Id.* Or, as here, an insurer can challenge the use of the Red Book at all on the basis that its values can never reflect an accurate AWP as used in Section 306(f.1)(3)(vi)(A), as that phrase has been interpreted by this Court. In *Indemnity Insurance*, we set forth standards that provided meaning to AWP: it is a price that is an industry average, not one that is "charged by a single manufacturer," and "is a number derived by averaging the wholesale prices of all manufacturers or wholesalers." 245 A.3d at 1167.

Respondent argues Petitioner's challenges to the Red Book must fail because, as in *Indemnity Insurance*, the testimony of Petitioner's witness, Selck, was not credited by the Hearing Officer. Petitioner acknowledges that this credibility determination cannot be revisited, but argues it is not relying on **its** witness's testimony, but on that provided by **Ortmann**, Respondent's expert. This Court acknowledges that the Hearing Officer, to whom it defers on credibility matters, credited Ortmann's testimony over Selck's testimony. However, the Hearing Officer only did so to the extent that the two experts gave **conflicting** testimony. (*See* FOF ¶ 25.)

A review of that testimony reveals that the witnesses' disagreements were more terminological than factual. Both witnesses agreed that NADAC pricing is based on the aggregated and averaged prices pharmacies actually pay for a drug at wholesale nationally, while Red Book pricing is chosen unilaterally by a drug's manufacturer, is not a mathematical average, and is not based on prices in any actual wholesale transactions. (R.R. at 104a-06a, 108a, 110a-12a, 135a-39a, 804a, 815a, 817a-22a, 824a.) They also agreed that NADAC and Red Book prices differ considerably, sometimes by orders of magnitude, particularly for generic drugs. (*Id.* at 118a, 808a-09a.) For example, Ortmann testified that while the wholesale

acquisition price for a bottle of Prozac was $9, the Red Book price for reimbursement was $2,000. (*Id.* at 808a-09a, 830a-31a.) Ortmann admitted that Red Book's AWP is **not a mathematical average**, but rather **a manufacturer's suggested price** that is used **as a reference** in **benefit negotiations** between pharmacies, PBMs, and third parties. (*Id*. at 836a.)

Ortmann's testimony is confirmed by the policy statement of "IBM Watson Health," the publisher of the Red Book in 2020, which was admitted as Exhibit J-1. That policy statement provides:

> [t]he . . . []AWP[] as published . . . is, in most cases, **the manufacturer's suggested AWP and does not reflect the actual AWP charged by a wholesaler**. . . . IBM Watson Health bases the AWP data it publishes on the following:
>
> - **AWP is reported by the manufacturer**[, defined as manufacturers, distributors, repackagers, and private labelers,] or
>
> - **AWP is calculated based on a markup specified by the manufacturer**. This markup is typically based on the Wholesale Acquisition Cost (WAC) or Direct Price (DIRP), **as provided by the manufacturer**, but may be based on other **pricing data provided by the manufacturer**, or
>
> - **Suggested Wholesale Price (SWP) [a]s reported by the manufacturer**[.]
>
> . . . .
>
> Please note that IBM Watson Health **does not perform any independent analysis to determine or calculate the actual AWP paid by providers**[, defined as retailers, hospitals, physicians, and others buying from the wholesaler or directly from the manufacturer for distribution to a patient,] **to wholesalers**.

(*Id.* at 843a (emphasis added).)

Returning to the standards set forth in *Indemnity Insurance*, an "accurate"

AWP under Section 306(f.1)(3)(vi)(A) is a price "use[d by] the industry" not one that is "charged by a single manufacturer," and "is a number derived by averaging the wholesale prices of all manufacturers or wholesalers." *Indem. Ins.*, 245 A.3d at 1167. The above cited evidence, found credible by the Hearing Officer, does not in any way reflect that the "AWP" contained in the Red Book meets the standards set forth in *Indemnity Insurance* for an "accurate" AWP. Thus, the Red Book values cannot be an "accurate" AWP.

Further, in rejecting Petitioner's argument that the Red Book should not be used, the Hearing Officer faulted Petitioner for not presenting "evidence of what the Red Book manufacturers['] prices are reported to Red Book for the drugs herein involved," "evidence as to what the wholesalers' prices are for the involved drugs as reported (or not reported) to Red Book," or "evidence as to any alleged average acquisition costs reported to Red Book . . . ." (Hearing Officer's Decision at 16.) While the first of this list was at least possible for Petitioner to have provided, if it had chosen to challenge the accuracy of the Red Book AWP for each of the disputed drugs, the latter items—the wholesalers' price and the average acquisition cost—are not data that is reported to or analyzed by Red Book per its policy statement. That statement reflects that it receives pricing data **from the manufacturer**, that data is **unrelated to what is actually charged by wholesalers to providers**, and that IBM Watson Health **performs no independent analysis to determine what is actually paid by providers to wholesalers**, i.e., acquisition costs. Ironically, these last two data points are more akin to what this Court identified in *Indemnity Insurance* as being needed to establish an accurate AWP, and neither are reported to Red Book. *See Indem. Ins.*, 245 A.3d at 1166 ("In short, the AWP provides an objective estimate of acquisition costs for pharmaceuticals available through national pricing

schedules.").

For these reasons, we agree with Petitioner that the Bureau's regulatory adoption and use of the Red Book's values as the "AWP" to resolve payment disputes for pharmaceuticals are inconsistent with the phrase "AWP" as used in Section 306(f.1)(3)(vi)(A), as interpreted by this Court. "An administrative agency's regulations cannot conflict with the statutory intention." *Stanish v. Workers' Comp. Appeal Bd. (James J. Anderson Constr. Co.)*, 11 A.3d 569, 575 (Pa. Cmwlth. 2010). If an agency's regulations "are contrary to the legislative intent of [the] statutory provisions to which they relate," they are invalid. *Id.* Accordingly, the regulations identifying the Red Book values as the AWP to be used to resolve payment disputes over pharmaceuticals are invalid, and the Hearing Officer erred in relying thereon to calculate the amount Petitioner must reimburse Respondent for the disputed drugs.

We must now turn to the remedy in this matter, as we hold that the Red Book's values cannot be used as AWP as a matter of law because they are inconsistent with the Act pursuant to our interpretation in *Indemnity Insurance*. Petitioner asserts this Court should simply reverse the Hearing Officer's Order and direct the use of the NADAC plus 110% as the appropriate AWP to resolve payment disputes. However, as Respondent points out, the Hearing Officer did not credit Selck's testimony regarding using the NADAC as a replacement index AWP for payment disputes. The Hearing Officer, in rejecting Petitioner's reliance on *Indemnity Insurance*, explained that *Indemnity Insurance* did not hold that an insurer "[wa]s 'free' to ignore [the] Red Book . . . and select some other modality which this adjudicator [wa]s somehow **obligated to accept**." (Hearing Officer Decision at 15 (emphasis added).) During the hearing, the Hearing Officer indicated, in response to

Petitioner's citation to *Indemnity Insurance*, that "reasonable minds may differ as to what *Indemnity Insurance* . . . means." (R.R. at 827a.)

We believe this opinion clarifies the meaning of *Indemnity Insurance*. And, although we agree with the Hearing Officer that he is not "obligated to accept," (Hearing Officer Decision at 15), an alternative modality or index offered by an insurer, any modality or index used as the AWP to resolve a payment dispute over pharmaceuticals must be "accurate" pursuant to the standards set forth in *Indemnity Insurance*. As discussed, the Red Book does not meet those standards. Thus, we are left with a record that includes the Red Book, which cannot be used due to its legal inconsistency with the Act, and an alternative index, the NADAC, which cannot be used due to the Hearing Officer's credibility determination. Accordingly, while we reverse the Hearing Officer's Order, a remand is required for further proceedings to determine the appropriate reimbursement due to Respondent.

However, per Section 127.131(b) of the regulations, the Bureau has the obligation to identify a "Nationally recognized schedule" that it will "us[e] to determine the AWP of prescription drugs" to resolve payment disputes and give notice of that schedule in the *Pennsylvania Bulletin* annually. 34 Pa. Code § 127.131(b). That is the AWP to be used to resolve that dispute **unless** an insurer submits an alternative AWP that is credited as being more "accurate" than the one identified by the Bureau. *Indemnity Insurance*, 245 A.3d at 1167-68. Having invalidated the Red Book, we direct the Bureau to promptly identify and publish in the *Pennsylvania Bulletin* a "Nationally recognized schedule," 34 Pa. Code § 127.131(b), that provides an AWP for pharmaceuticals that comports with Section 306(f.1)(3)(vi)(A) of the Act, as interpreted by *Indemnity Insurance* and this opinion, to be used to resolve payment disputes. The Hearing Officer shall stay the remand

evidentiary hearing until the Bureau publishes a new schedule, after which the hearing will be held to allow the parties to introduce, if necessary, evidence regarding alternative indices or schedules they believe provide a more "accurate" AWP under the *Indemnity Insurance* standard. In evaluating that evidence, the Hearing Officer must consider which of the indices or schedules offered present the more "accurate" AWP under *Indemnity Insurance* and resolve the payment dispute using that AWP plus 110% as directed by Section 306(f.1)(3)(vi)(A).

III. CONCLUSION

Because we conclude that the Red Book values adopted and used by the Bureau as the AWP to resolve payment disputes for pharmaceutical drugs is inconsistent with the statutory language of Section 306(f.1)(3)(vi)(A) and is, therefore, invalid, *Stanish*, 11 A.3d at 575, we reverse the Order directing Petitioner to reimburse Respondent 110% of the Red Book values for the disputed drugs in this matter. We remand for further proceedings before the Hearing Officer. However, the Hearing Officer shall stay those proceedings pending the Bureau's identification of a "Nationally recognized schedule" of AWP to be used in payment disputes and publication of that schedule in the *Pennsylvania Bulletin* as required by Section 127.131(b) of the regulations, 34 Pa. Code § 127.131(b). The Bureau is directed to perform these actions promptly. Upon the Bureau's completion of this obligation, the Hearing Officer shall hold an evidentiary hearing and render a new decision in accordance with the foregoing opinion.

RENÉE COHN JUBELIRER, President Judge

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

Federated Insurance Company, Petitioner	: :	
v.	:	No. 115 C.D. 2023
Summit Pharmacy (Bureau of Workers' Compensation Fee Review Hearing Office), Respondent	: :	

O R D E R

NOW, January 2, 2024, the Order of the Bureau of Workers' Compensation (Bureau) Fee Review Hearing Office, entered in the above-captioned matter, is **REVERSED**, and this matter is **REMANDED** for further proceedings and a new determination in accordance with the foregoing opinion. Additionally, the Bureau is **DIRECTED** to promptly identify and publish in the *Pennsylvania Bulletin* a "Nationally recognized schedule[] to determine the [average wholesale price] of prescription drugs" to be used to resolve payment disputes, 34 Pa. Code § 127.131(b), that comports with Section 306(f.1)(3)(vi)(A) of the Workers' Compensation Act, Act of June 2, 1915, P.L. 736, *as amended*, 77 P.S. § 531(3)(vi)(A), as interpreted by *Indemnity Insurance Company of North America v. Bureau of Workers' Compensation Fee Review Hearing Office (Insight Pharmacy)*, 245 A.3d 1158, 1167 (Pa. Cmwlth. 2021), and the foregoing opinion. The Hearing Officer shall stay the remand proceedings pending the Bureau's publication of a new schedule, after which the remand proceedings shall be held.

Jurisdiction relinquished.

Renée Cohn Jubelirer

RENÉE COHN JUBELIRER, President Judge

Order Exit
01/02/2024

Harburg Med. Sales Co. v. Pma Mgmt. Corp.

Commonwealth Court of Pennsylvania

June 7, 2021, Submitted; August 30, 2021, Decided; August 30, 2021, Filed

No. 635 C.D. 2020

Reporter
2021 Pa. Commw. Unpub. LEXIS 476 *; 263 A.3d 71; 2021 WL 3852290

Harburg Medical Sales Co., Petitioner v. PMA Management Corp. (Bureau of Workers' Compensation, Fee Review Hearing Office), Respondent

Notice: PUBLISHED IN TABLE FORMAT IN THE ATLANTIC REPORTER.

An unreported opinion of the Commonwealth Court may be cited and relied upon when it is relevant under the doctrine of law of the case, res judicata or collateral estoppel. Parties may also cite an unreported panel decision of the Commonwealth Court issued after January 15, 2008 for its persuasive value, but not as binding precedent. A single-judge opinion of the Commonwealth Court, even if reported, shall be cited only for its persuasive value, not as a binding precedent.

Subsequent History: Appeal denied by Harburg Med. Sales Co. v. PMA Mgmt. Corp., 2022 Pa. LEXIS 388 (Pa., Mar. 31, 2022)

Judges: [*1] BEFORE: HONORABLE P. KEVIN BROBSON, President Judge, HONORABLE J. ANDREW CROMPTON, Judge (P.), HONORABLE BONNIE BRIGANCE LEADBETTER, Senior Judge. MEMORANDUM OPINION BY SENIOR JUDGE LEADBETTER.

Opinion by: BONNIE BRIGANCE LEADBETTER

Opinion

MEMORANDUM OPINION BY SENIOR JUDGE LEADBETTER

Petitioner, Harburg Medical Sales Co., petitions for review of two adjudications of the Bureau of Workers' Compensation, Fee Review Hearing Office,[1] denying Harburg's requests for *de novo* hearings to contest the Bureau's administrative denial of fee review applications relative to an injured worker, Walter Maximo, on the ground that Harburg was not a provider within the meaning of Section 109 of the Workers' Compensation Act (Act)[2] and, therefore, lacked standing to invoke the fee review process. We affirm.

The pertinent background of this matter is as follows. In July 2002, Maximo sustained a work injury in the course of his employment with Case Paper Company. (June 15, 2020 Adjud., Finding of Fact "F.F." No. 2.) After he

---

[1] The two adjudications, captioned Dispute Nos. DSP-2417595-12 and DSP-2417595-16, respectively, pertain to merged Dispute Nos. DSP-2417595-12 through 19. Bearing the same circulation date, the adjudications are identical but for the cover pages and order captions. For citation purposes, we refer to them together as the June 15, 2020 Adjudication.

[2] Act of June 2, 1915, P.L. 736, *as amended*, added by the Act of July 2, 1993, P.L. 190, 77 P.S. § 29. In the context of fee reviews, "'[p]rovider' means a health care provider." *Id.* Hence, we use the terms health care provider and provider interchangeably in the present case.

developed chronic pain, his doctor sent orders for certain pain treatment modalities to Harburg. (*Id.*, No. 3.) Upon receiving the orders, "Ms. Harburg [] communicate[d] with various distributors (never identified, except—at one point—as **[*2]** Amazon, in these proceedings)," advanced payment for the items, and directed them to be delivered to Maximo's residence via UPS or FedEx.[3] (*Id.*) Thereafter, Harburg billed PMA Management Corporation, Case Paper Company's third-party administrator. (*Id.*)

Following a dispute between Harburg and PMA as to the amount properly payable for the items, Harburg filed fee review applications with the Bureau. Upon the Bureau's denial of the applications, Harburg sought further review by requesting *de novo* hearings. (*Id.*, Nos. 4-6.) In the interim, PMA moved to dismiss the applications on the grounds that Harburg was not a provider and that the Hearing Office lacked jurisdiction to address the issue of whether an entity was a provider. The Hearing Office denied the motion to dismiss based on the then-controlling case law.[4]

Subsequently, this Court issued two decisions impacting the instant case. In *Armour Pharmacy v. Bureau of Workers' Compensation Fee Review Hearing Office (Wegman's Food Markets, Inc.)*, 206 A.3d 660, 671 (Pa. Cmwlth. 2019) (en banc) (*Armour I*), we held that the Hearing Office had jurisdiction to determine whether a supplier was a provider. Thereafter, we directed the Hearing Office in a related series of cases to adjudicate the threshold issue of whether Harburg was a provider. *PMA Mgmt. Corp. v. Bureau of Workers' Comp. Fee Rev. Hearing Off. (Harburg Med. Sales, Co., Inc.)*, No. 1757 C.D. 2017, 208 A.3d 211 (Pa. Cmwlth., filed Apr. 12, 2019) **[*3]** . Pursuant to that directive, Hearing Officer David Torrey conducted a hearing and concluded that Harburg was not a provider. Harburg's petition for review followed.

Section 306(f.1)(5) of the Act provides that a health care provider that "disputes the amount and timeliness of the payment from the employer or insurer shall file an application for fee review . . . ." 77 P.S. § 531(5). Section 109 of the Act defines a "health care provider" as follows:

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

77 P.S. § 29.

In determining that Harburg does not meet the definition of provider, we first note that it is neither licensed nor authorized by the Commonwealth to provide health care services. Ms. Harburg acknowledged **[*4]** that she had no relevant degrees or certifications as a health care provider. (Jan. 20, 2015 Harburg Dep., Notes of Test. "N.T." at 52; Reproduced R. "R.R." at 118a.) Additionally, as she opined

---

[3] Stating that it would not be cost effective to examine the items before shipment, Ms. Harburg acknowledged that she was unfamiliar with many of their features. (F.F. Nos. 12-14.)

[4] The Hearing Office relied on *Selective Insurance Co. of America v. Bureau of Workers' Compensation Fee Review Hearing Office (The Physical Therapy Institute)*, 86 A.3d 300 (Pa. Cmwlth. 2014), which this Court subsequently overruled to the extent that it was inconsistent with *Armour Pharmacy v. Bureau of Workers' Compensation Fee Review Hearing Office (Wegman's Food Markets, Inc.)*, 206 A.3d 660 (Pa. Cmwlth. 2019) (en banc) *(Armour I)*.

and to our understanding, there are no government agencies specifically authorizing Harburg to distribute medical supplies, no state or federal quality standards for suppliers of such items, and no continuing education requirements for operating a medical supply company. (Aug. 21, 2019 Harburg Dep., N.T. at 12-13; R.R. at 448a-49a.) Further, she acknowledged that Harburg is not accredited by Medicare as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies supplier.[5] (*Id.* at 11-12; R.R. at 447a-48a.)

Moreover, the limited certificate of registration from the Pennsylvania Department of Health that Harburg submitted does not establish that it is a provider under the Act or otherwise authorized to provide health care services. The certificate indicates that Harburg is registered to conduct and maintain a facility in accordance with The Controlled Substance, Drug, Device and Cosmetic Act (Drug Act)[6] and that the category for which it is registered is "devices," which does not permit the **[*5]** possession or sale of controlled substances or prescription drugs. (Aug. 21, 2019 Harburg Dep., Harburg Ex. 1; R.R. at 468a.) In pertinent part, the Drug Act defines "device" as "instruments, apparatus and contrivances, including their components, parts and accessories . . . ." Section 102 of the Drug Act, 35 P.S. § 780-102. However, even if such a certificate did indicate that Harburg was a provider, the applications at issue do not include devices under the Drug Act. As the parties stipulated:

> (1) in the pending Medical Fee Review (MFR) matters, Harburg arranged for disposable and/or durable medical supplies to be delivered to the injured worker (IW) in the underlying [w]orkers' [c]ompensation case. Supplies included but were not limited to, heat wraps, cold wraps, and supplies for use with a Tens Unit[;] (2) in each MFR, there is a licensed health care provider who treats the IW, and who recommended, ordered, prescribed, or authored a letter of medical necessity for the disposable and/or durable medical supplies for the IW's use.

(F.F. No. 11.) In addition, the certificate bears an issuance date of March 28, 2015, with an expiration date of April 30, 2020, which is outside of the periods at issue in the instant **[*6]** fee review applications. Consequently, the limited certificate is irrelevant.

As additional support for the determination that Harburg is not a provider, we turn to the relevant findings of fact indicating how the approximately thirty-year-old company operates. Co-owned by a husband and wife, Harburg "maintains an enterprise [run from home with no warehouse or inventory] that facilitates the home delivery, via mail order, of certain medical supplies." (F.F. No. 12.) As extrapolated from that part of Ms. Harburg's testimony that the Hearing Officer credited,[7] he

---

[5] Ms. Harburg testified that Harburg is not a Medicare provider, instead primarily billing workers' compensation carriers and third-party administrators. (Jan. 20, 2015 Harburg Dep., N.T. at 14; R.R. at 450a; and Aug. 21, 2019 Harburg Dep., N.T. at 6; R.R. at 361a.)

[6] Act of April 14, 1972, P.L. 233, *as amended*, 35 P.S. §§ 780-101-780-144.

[7] The Hearing Officer acknowledged that some segments of Ms. Harburg's rejected testimony do not bear directly on Harburg's standing as a provider. Nonetheless, he observed that the omissions and irregularities in Ms. Harburg's testimony "cast grave question upon the integrity of the medical billing which has unfolded in these fee reviews." (F.F. No. 18.) In pertinent part, he rejected Ms. Harburg's testimony that Harburg is not a middleman; that Ms. Harburg personally dispenses items; that injured workers cannot go to retail outlets to buy certain items; and that the types of products that Harburg deals in are not directly available for purchase. Additionally, he rejected Ms. Harburg's testimony justifying use of durable medical equipment codes for items such as disposable heat and cold wraps. (*Id.*, No. 12) Instead, he credited the testimony of

found as follows. "Patients do not come to [Ms. Harburg's] office; instead, . . . she undertakes mail orders from doctor referrals or when the patient contacts her directly." (*Id.*, No. 12.) Ms. Harburg instructs the "vendor to ship out whatever the doctor ordered." (*Id.*) Additionally, someone on behalf of Harburg calls the "patient" before dispensing, asking whether he or she wants to "cut down from what the doctor ordered[.]" (*Id.*) Someone also calls the patient to ascertain whether "he or she needs ongoing deliveries of the pain management items." (*Id.*)

Further, the facts do not warrant a legal determination that **[*7]** Harburg is an agent of a licensed health care provider. In that respect, the Hearing Officer properly rejected "Harburg's assertion that it is a health care provider for fee review purposes [based on] the theory that it is an agent of certain physicians who FAX over . . . slips for pain treatment items like hot and cold wraps." (Conclusion of Law "C.L." No. 2.) Instead, the evidence reflects that Harburg "is operating what is, in effect, a service directly to injured workers." (*Id.*) As Ms. Harburg stated: "[T]he patient—when they call, I mean, I had one just call two weeks ago. And she [had] settled [and hence the insurance company was out of the picture]. And she said please help me. You were great and I want to buy it from you . . . ." (*Id.*) In other words, Harburg "is a mail-order facilitator of injured workers'/claimants' desire for therapeutic pain management items like hot wraps." (*Id.*, No. 17(a).) Accordingly, Harburg is not an agent within the meaning of Section 109 of the Act.

In addition, we reject Harburg's argument that the Hearing Officer's decision violated Harburg's due process rights by depriving it of a forum to contest the amount or timeliness of the payments received from the **[*8]** employer or the insurer. Even though Harburg may have rendered convenient services or assisted injured workers to obtain equipment or supplies that were part of his or her treatment plan, the pertinent legislation does not dictate that any person or entity which does so be afforded an opportunity to invoke the fee review process. Pursuant to the clear language of Section 306(f.1)(5) of the Act, only providers have standing to do so. "In the absence of ambiguity in the statutory language, we will not embark on a statutory construction exercise; rather, we will apply the plain language of the statute." *Barringer v. State Emps.' Ret. Bd.*, 987 A.2d 163, 165-66 (Pa. Cmwlth. 2009). If the General Assembly wishes to expand the definition of provider in legislation pertaining to medical cost containment and the fee review process, then it needs to enact appropriate laws.

In any case, we conclude that Harburg was not deprived of its due process rights. In *Armour I*, this Court held that "[i]t offend[ed] due process . . . as well as the Act's careful scheme for resolving fee disputes to place the question of whether a putative provider is actually a 'provider' beyond the reach of judicial review." *Armour I*, 206 A.3d 670. Hence, we determined that the Hearing Office has jurisdiction to determine whether a supplier **[*9]** is a provider. *Id.* at 671. Harburg was given a full hearing on this issue and afforded due process; it simply did not agree with either the result or the consequences necessarily following therefrom—its inability to invoke the fee review process. Determining the legal status of Harburg ends our inquiry. As Hearing Officer Torrey concluded: "It may well be that some

---

Michael Miscoe, a certified coder, that Harburg is providing medical items that are readily available for purchase at retail outlets such as Rite Aid and that it is improper to use durable medical codes for disposable items like hot and cold wraps. (*Id.*, Nos. 16 and 20.)

medical supply houses are, somehow, providers under the Act, and have standing to file Requests in this forum. However, on the evidence presented in this case, Harburg is not one of them." (C.L. No. 5.)

Accordingly, we affirm.

BONNIE BRIGANCE LEADBETTER,

President Judge Emerita

ORDER

AND NOW, this 30th day of August, 2021, the orders of the Bureau of Workers' Compensation, Fee Review Hearing Office, are hereby AFFIRMED.

BONNIE BRIGANCE LEADBETTER,

President Judge Emerita

Keystone Rx LLC v. Bureau of Workers' Comp. Fee Rev. Hearing Off.

Supreme Court of Pennsylvania

April 13, 2021, Argued; December 22, 2021, Decided

No. 27 EAP 2020, No. 28 EAP 2020

Reporter
265 A.3d 322 *; 2021 Pa. LEXIS 4275 **; 2021 WL 6057884

KEYSTONE RX LLC, v. BUREAU OF WORKERS' COMPENSATION FEE REVIEW HEARING OFFICE (COMPSERVICES INC./AMERIHEALTH CASUALTY SERVICES); APPEAL OF: COMPSERVICES/AMERIHEALTH CASUALTY SERVICES;KEYSTONE RX LLC v. BUREAU OF WORKERS' COMPENSATION FEE REVIEW HEARING OFFICE (COMPSERVICES INC./AMERIHEALTH CASUALTY SERVICES); APPEAL OF: BUREAU OF WORKERS' COMPENSATION FEE REVIEW HEARING OFFICE

Prior History: Keystone Rx LLC v. Bureau of Workers' Comp. Fee Review Hearing Office (Compservices Inc.), 223 A.3d 295, 2019 Pa. Commw. LEXIS 1097, 2019 WL 6754832 (Pa. Commw. Ct., Dec. 12, 2019)

Case Summary

Overview
HOLDINGS: [1]-The Commonwealth Court erred by concluding that the Workers' Compensation Act improperly failed to account for the due process rights of non-treating providers in utilization review (UR) proceedings and by engrafting onto the Act a requirement that non-treating providers receive notice of and an opportunity to intervene in UR proceedings because when an insurer successfully challenged a treatment, the Act made clear that a non-treating provider did not have a constitutionally-protected property interest in goods or services that it dispensed, as those providers were never entitled to payment under the Act, but rather, they simply had an expectation of payment in the normal course, and absent a constitutionally protected property interest, there was no viable due process claim.

Outcome
Portion of lower court's opinion rejected. Order otherwise affirmed.

LexisNexis® Headnotes

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Employee Rights

HN1[] **Medical Benefits, Authorized Treatment**

Section 306(f.1)(1)(i) of the Workers' Compensation Act (Act) requires employers and their insurers to pay the costs of reasonable surgical and medical services, medicines, and supplies as and when needed for work injuries

sustained by their employees. 77 Pa. Stat. Ann. § 531(1)(i). The Act provides that disputes regarding the reasonableness or necessity of treatment by a health care provider shall be resolved by a utilization review, i.e., utilization review, at the request of an employee, employer, or insurer. 77 Pa. Stat. Ann. § 531(6)(i). Utilization reviews are conducted by health care providers licensed in the same profession and having the same or similar specialty as that of the provider of the treatment under review. 77 Pa. Stat. Ann. § 531(6)(i).

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Employee Rights

HN2 **Medical Benefits, Authorized Treatment**

If a treating provider, employer, employee or insurer disagrees with the result of the utilization review, a petition for review must be filed. 77 Pa. Stat. Ann. § 531(6)(iv) explains that in disputes as to reasonableness or necessity of treatment, if the provider, employer, employee or insurer disagrees with the finding of the utilization review organization, a petition for review by the department must be filed within 30 days after receipt of the report. The Workers' Compensation Act dictates that, after a petition for review is filed by one of these parties, a workers' compensation judge (WCJ) must hold a hearing at which the WCJ may make recommendations that will control only if all parties agree that the WCJ's recommendations will be binding. 77 Pa. Stat. Ann. § 711.1. The Act does not permit non-treating providers that deliver services in conjunction with a claimant's medical treatment, such as pharmacies, to participate in the utilization review process. The Act, however, contains a fee review process that allows these non-treating entities to dispute the amount or timeliness of the payment from the employer or insurer. 77 Pa. Stat. Ann. § 531(5).

Business & Corporate Compliance > ... > Contracts Law > Types of Contracts > Releases

Constitutional Law > ... > Fundamental Rights > Procedural Due Process > Scope of Protection

HN3 **Types of Contracts, Releases**

As a matter of due process, the parties to a subsequent agreement regarding liability can bind each other, but they cannot release themselves from liability to a person who is not a party to the agreement and who has been given neither notice nor opportunity to be heard on the agreement.

Civil Procedure > Appeals > Standards of Review > De Novo Review

Civil Procedure > Appeals > Standards of Review > Questions of Fact & Law

HN4 **Standards of Review, De Novo Review**

Consideration of the constitutionality of a statute presents a question of law; accordingly, the appellate court's standard of review is de novo, and its scope of review is plenary.

Governments > Legislation > Interpretation

HN5[] **Legislation, Interpretation**

It is axiomatic that courts may not add statutory language where they find the extant language somehow lacking.

Constitutional Law > ... > Case or Controversy > Constitutionality of Legislation > Inferences & Presumptions

Evidence > Burdens of Proof > Allocation

HN6[] **Constitutionality of Legislation, Inferences & Presumptions**

Every piece of legislation passed by the General Assembly enjoys the strong presumption that it is constitutional. Thus, a party challenging the constitutionality of a statute bears a very heavy burden of persuasion. Indeed, a court will not deem a legislative enactment unconstitutional unless it clearly, palpably, and plainly violates the Constitution. If there is any doubt that a challenger has failed to reach this high burden, then that doubt must be resolved in favor of finding the statute constitutional.

Constitutional Law > Substantive Due Process > Scope

Constitutional Law > ... > Fundamental Rights > Procedural Due Process > Scope of Protection

HN7[] **Constitutional Law, Substantive Due Process**

The Fourteenth Amendment to the United States Constitution provides that no State may deprive any person of life, liberty, or property, without due process of law. U.S. Const. amend. XIV. The first inquiry in every due process challenge is whether the complaining party has been deprived of a protected interest in property or liberty.

Governments > Legislation > Interpretation

HN8[] **Legislation, Interpretation**

Pursuant to the Statutory Construction Act, the object of all statutory construction is to ascertain and effectuate the General Assembly's intention. 1 Pa.C.S. § 1921(a). When the words of a statute are clear and free from ambiguity, the letter of the statute is not to be disregarded under the pretext of pursuing its spirit. 1 Pa.C.S. § 1921(b).

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Employee Rights

HN9[] **Medical Benefits, Authorized Treatment**

The Workers' Compensation Act clearly and unambiguously provides that employers and insurers are obligated to pay providers for reasonable and necessary treatment or services connected to claimants' work-related injuries. 77 Pa. Stat. Ann. § 531(1)(i) provides that the employer shall provide payment in accordance with this section for reasonable surgical and medical services, services rendered by physicians or other health care providers, including an additional opinion when invasive surgery may be necessary, medicines and

supplies, as and when needed. Section 531(5) provides that the employer or insurer shall make payment in accordance with the provisions of this section. Indeed, the Act mandates that employers or insurers pay providers within 30 days of the receipt of bills; however, that obligation is, at least temporarily, eliminated if employers or insurers dispute the reasonableness or necessity of the treatment at issue. Section 531(5) provides that all payments to providers for treatment provided pursuant to this act shall be made within 30 days of receipt of such bills and records unless the employer or insurer disputes the reasonableness or necessity of the treatment provided pursuant to § 531(6), which addressed utilization review.

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

***HN10*[⬇] Medical Benefits, Authorized Treatment**

If an employer or insurer triggers the utilization review mechanism for challenging the reasonableness or necessity of treatment, then the employer or insurer is not obligated to pay for the treatment unless the utilization review results in a determination that the treatment at issue was reasonable and necessary.

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Employee Rights

***HN11*[⬇] Medical Benefits, Authorized Treatment**

When a non-treating provider bills an insurer and the insurer invokes the utilization review process, the non-treating provider is not entitled to payment under the Workers' Compensation Act. Further, if the utilization review results in a determination that the treatment at issue is unreasonable or unnecessary, the employer and insurer are not liable under the Act to pay for the treatment. 77 Pa. Stat. Ann. § 531(1)(i). The Act expressly limits an employee's entitlement to reasonable and necessary medical treatment, and requires that disputes over the reasonableness and necessity of particular treatment must be resolved before an employer's obligation to pay, and an employee's entitlement to benefits, arise. On the other hand, if a utilization review results in a conclusion that the treatment was reasonable and necessary, then the non-treating provider is entitled to payment under the Act and has the fee review process to litigate the amount or timeliness of the payment from the employer or insurer.

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

***HN12*[⬇] Medical Benefits, Authorized Treatment**

When an insurer successfully challenges a treatment, the Workers' Compensation Act makes clear that a non-treating provider does not have a constitutionally-protected property interest in goods or services that it dispensed, as these providers were never entitled to payment under the Act; rather, they simply have an expectation of payment in the normal course.

Counsel: [1]** For Compservices

Inc./AmeriHealth Casualty Services, Appellant: McCoy, Jay Brandon Todd, Bilotti, Anthony J., Anthony J. Bilotti & Associates, L.L.C., Media, PA.

For The Coalition Against Insurance Fraud, Appellant Amicus Curiae: Copeland, Audrey Jacobsen, Natale, Anthony, III, Marshall, Dennehey, Warner, Coleman & Goggin, P.C., King of Prussia, PA; Punturi, Michele R., Marshall Dennehey Warner Coleman & Goggin, King of Prussia, PA.

For Insurance Federation of Pennsylvania, et al., Appellant Amicus Curiae: Myers, Karl Stewart, Stradley, Ronon, Stevens & Young, LLP, Philadelphia, PA; Davis, Steven Burgess, Stradley Ronon Steven Et Al, Philadelphia, PA.

For Laundry Owners Mutual Liability Insurance Association, et al., Appellant Amicus Curiae: Tunstall, Lori Anne, Weber Gallagher Simpson Stapleton Fires & Newby, LLP, Philadelphia, PA; Gooden, Shawn C., Weber Gallagher Simpson Stapleton Fires & Newby, LLP, Harrisburg, PA.

For Bureau of Workers' Compensation Fee Review Hearing Office, Appellee: Schwartz, Deborah Jean, Pennsylvania Department of Labor & Industry, Pa Dept. Of Labor And Industry, Harrisburg, PA; Mazin, Kimberly Dawn, Dept Of L & I Workers'Comp Div-Occ, Harrisburg, PA; Preputnick, **[**2]** Eric G., Commonwealth of Pennsylvania, Bureau Of Workman's Comp, Harrisburg, PA.

For Keystone Rx LLC, Appellee: Siegel, Daniel Joel, Law Offices of Daniel J. Siegel, L.L.C., Havertown, PA.

Judges: BAER, C.J., SAYLOR, TODD, DONOHUE, DOUGHERTY, WECHT, MUNDY, JJ. Justices Saylor, Todd, Donohue, Dougherty, Wecht and Mundy join the opinion. Justice Wecht files a concurring opinion in which Justice Dougherty joins.

Opinion by: BAER

Opinion

[*324] CHIEF JUSTICE BAER

In this workers' compensation matter, the Bureau of Workers' Compensation Fee Review Hearing Office ("Hearing Office") concluded that, in the fee review setting, a non-treating healthcare provider, like a pharmacy, cannot challenge a utilization review ("UR") determination that medications prescribed by a treating healthcare provider, such as a physician, but dispensed by the non-treating entity, were **[*325]** unreasonable and unnecessary for the treatment of a claimant's work-related injury. The Commonwealth Court affirmed the Hearing Office's order. However, after reaching this result, the intermediate court held that for UR procedures occurring in the future, when an employer, insurer or an employee requests UR, non-treating providers, such as pharmacies, must be afforded **[**3]** notice and an opportunity to establish their right to intervene in the UR proceedings. *Keystone Rx LLC v. Bureau of Workers' Comp. Fee Review Hearing Office (Compservices Inc.)*, 223 A.3d 295, 299 (Pa. Cmwlth. 2019) ("*Keystone Rx*"). While we affirm the Commonwealth Court's result, we respectfully reject its prospective holding that non-treating healthcare providers must be given notice and an opportunity to intervene in UR proceedings.

HN1[⬆] By way of a statutory background, Section 306(f.1)(1)(i) of the Workers' Compensation Act ("Act") requires employers and their insurers to pay the costs of "reasonable surgical and medical services, . . . medicines[,] and supplies as and when needed"

for work injuries sustained by their employees. 77 P.S. § 531(1)(i). The Act provides that disputes regarding the "reasonableness or necessity of treatment by a health care provider" shall be resolved by a UR, *i.e.*, utilization review, "at the request of an employe, employer, or insurer." 77 P.S. § 531(6)(i). URs are conducted by health care providers "licensed in the same profession and having the same or similar specialty as that of the provider of the treatment under review." 77 P.S. § 531(6)(i).[1]

HN2[↑] If a treating "provider, employer, employe or insurer" disagrees with the result of the UR, a petition for review must be filed. *See* 77 P.S. § 531(6)(iv) (explaining that in disputes as to reasonableness or necessity of treatment, if "the provider, employer, employe or insurer disagrees with the finding of the utilization review organization, a petition for review by the department must be filed within thirty (30) days after receipt of the report"). The Act dictates that, after a petition for review is filed by one of these parties, **[**5]** a workers' compensation judge ("WCJ") must hold a hearing at which the WCJ may make recommendations that will control only if all parties agree that the WCJ's recommendations will be binding. 77 P.S. § 711.1. The Act does not permit non-treating providers that deliver services in conjunction with a claimant's medical treatment, such as pharmacies, to participate in the UR process. The Act, however, contains a fee review process that allows these non-treating entities to dispute "the amount or timeliness of the payment from the employer or insurer." 77 P.S. § 531(5).[2]

[*326] Turning to the factual background of this case, Thomas Shaw ("Claimant"), an employee of the Roman Catholic Archdiocese of Philadelphia ("Employer"), suffered a workplace-related left knee injury in 2014.[3] Claimant sought and received medical care from a physician, Dr. Bradley Ferrara

---

[1] This subsection of the Act states as follows:

> Except in those cases in which a workers' compensation judge asks for an opinion from peer review under Section 420, disputes as to reasonableness or necessity of treatment by a health care provider shall be resolved in accordance with **[**4]** the following provisions:
>
> (i) The reasonableness or necessity of all treatment provided by a health care provider under this act may be subject to prospective, concurrent or retrospective utilization review at the request of an employe, employer or insurer. The department shall authorize utilization review organizations to perform utilization review under this act. Utilization review of all treatment rendered by a health care provider shall be performed by a provider licensed in the same profession and having the same or similar specialty as that of the provider of the treatment under review. Organizations not authorized by the department may not engage in such utilization review.

77 P.S. § 531(6)(i).

[2] This subsection of the Act states as follows:

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

77 P.S. § 531(5) (emphasis added).

[3] Employer is not a party to this appeal.

("Physician"), including prescriptions for medications starting in April of 2015 and continuing until at least April of 2017. Keystone Rx LLC ("Pharmacy") **[**7]** dispensed the medications to Claimant and billed Employer's insurer, Compservices/AmeriHealth Casualty Services ("Insurer").

Insurer filed a UR request in 2017 regarding medical treatment, including medications prescribed by Physician and dispensed by Pharmacy, that Shaw received after November 2, 2016. Because Pharmacy was not a treating provider for purposes of the UR procedures of the Act, it was not a party to the UR process. The result of the UR was a determination that all treatment rendered by Physician after November 2, 2016, including the prescribed medications that Pharmacy dispensed to Claimant, was unreasonable and unnecessary because it was unrelated to Claimant's workplace injury. Claimant filed two petitions to review the UR determination, but those petitions were later withdrawn pursuant to a Compromise and Release ("C&R") Agreement that resolved Claimant's then-pending claims but left open whether he could receive future medical coverage for his workplace injury. This outcome meant that Insurer was not required to pay Pharmacy under the Act for the aforementioned medications that Pharmacy provided to Claimant.

Pharmacy then filed the two applications for fee review that **[**8]** are at issue in this appeal. The Medical Fee Review Section of the Department of Labor and Industry ("Fee Review Section") held a hearing on the applications, after which it concluded that Insurer owed Pharmacy over $4,000 for providing Claimant the medications at issue in this case. Insurer sought and was granted a hearing to contest this conclusion, as it believed that any need for these medications was unrelated to Claimant's work injury because the medications were found to be unreasonable and unnecessary for treatment of Claimant's work-related injury during the UR process.

After a hearing, Hearing Office ruled in favor of Insurer by vacating the previously entered administrative determinations and dismissing Pharmacy's applications for fee review. The Hearing Office concluded that **[*327]** Insurer met "its burden of proving that the medications prescribed by [Physician] had been classified as unreasonable and unnecessary treatment via the Utilization Review process." Petition for Review, 10/15/2018, Exhibit A, at 13. In reaching this conclusion, the Hearing Office explained that Pharmacy did not have standing in a fee review procedure to challenge the UR determination that the medications **[**9]** prescribed by Physician were unreasonable and unnecessary. The Hearing Office also rejected Pharmacy's argument that the Commonwealth Court's decision in *Armour Pharmacy v. Bureau of Workers' Compensation Fee Review Hearing Office (National Fire Insurance Company of Hartford)*, 192 A.3d 304 (Pa. Cmwlth. 2018) ("*Armour*"), a case we discuss in more detail *infra*, holds that non-treating providers may not be deprived of compensation in the workers' compensation setting without receiving due process.

Pharmacy then filed a petition for review in the Commonwealth Court, where Pharmacy relied upon *Armour* for the proposition that non-treating providers are entitled to payment from a workers' compensation carrier for prescriptions issued at the request of a treating provider unless that entitlement is removed by a procedure, such as UR, that provides it due process protections. Pharmacy argued that

pursuant to *Armour*, its due process rights were violated because the Act does not allow non-treating providers to participate in the UR process, even though UR determinations are binding on them.

Because the Commonwealth Court's decision in this matter requires an understanding of that court's opinion in *Armour*, we pause to summarize that decision. In *Armour*, an employer was required to provide medical treatment pursuant to the Act for its employee's work-related injury. A physician **[**10]** prescribed medication to treat the injury, and a pharmacy dispensed the medication; however, the employer refused to pay the pharmacy for the medication and requested UR, claiming that the medication prescribed by the physician was not necessary to treat the employee's work-related injury. At the conclusion of the UR, the medication was found to be reasonable and necessary to treat the employee's injury. Subsequently, because the employer continued to fail to pay for the treatment, the pharmacy that dispensed the medication filed a fee review application, seeking payment from the employer for the medication.

The Fee Review Section concluded that, based on the UR determination, the employer was required to pay the pharmacy for the medication. Thereafter, the employer requested a hearing with the Hearing Office to contest that determination. After the employer sought this review, the employer and the claimant entered into negotiations outside of the UR and fee review processes, leading to their execution of a release agreement that explicitly relieved the employer of any liability for the prescription. The employer then pursued its challenge to the Fee Review Section's determination, **[**11]** arguing to the Hearing Office that the release agreement between it and the claimant should control whether it owed the pharmacy for the medication. The Hearing Office agreed with the employer and vacated the Fee Review Section's determination.

The pharmacy appealed to the Commonwealth Court, contending that its due process rights were violated because it was deprived of its right to payment based on an agreement: (1) releasing the employer of its obligations imposed during the UR and fee review proceedings; (2) that was reached outside of the UR and fee review proceedings; (3) and to which the pharmacy was not a party. The Commonwealth **[*328]** Court in *Armour* concluded that an agreement between an employer and claimant, reached after a UR determination that medications dispensed by a pharmacy were reasonable and necessary, but outside of the UR and fee review processes, could not be used to set aside a fee review determination that an employer was obligated to pay a pharmacy where the pharmacy was not a party to the agreement. ***HN3***[⬆] The court held that, as a matter of due process, the parties to a subsequent agreement regarding liability "can bind each other, but they cannot release themselves from liability **[**12]** to a person who is not a party to the [agreement] and who has been given neither notice nor opportunity to be heard on the [agreement]." *Armour*, 192 A.3d at 312. Accordingly, the court vacated the Hearing Office's determination and remanded for further proceedings.

Turning back to the instant matter, in a published opinion, the Commonwealth Court affirmed the Hearing Office's order, holding that Pharmacy was not entitled to payment. *Keystone Rx, supra*. In so doing, the court reasoned that *Armour* was distinguishable from the present matter. The court emphasized that,

unlike the instant case, *Armour* was based on an agreement between the employer and claimant that was created outside of the UR and fee review processes. Further, the intermediate court noted that the result of the UR proceeding in *Armour* was a determination that the treatment received by the claimant was reasonable and necessary; whereas here, a determination was made that the treatment was unreasonable and unnecessary.

Consistent with this reasoning, the court concluded that, because the UR resulted in a determination that the medications prescribed by Physician were unreasonable and unnecessary, the Hearing Office correctly concluded that it could not address in the fee review setting **[**13]** Pharmacy's attack on "the facial validity of the UR process[.]" *Keystone Rx*, 223 A.3d at 299. The court, however, did not end its analysis there.

Instead, the Commonwealth Court then purported to "acknowledge that there are due process issues for [non-treating] providers such as Pharmacy that are precluded from participating in the UR process but nonetheless are bound by the results that follow them to the fee review process at issue herein." *Id.* Based upon its assessment that "the polestar of *Armour* [] is that the Act must be construed in accordance with due process of law[,]" the court further held that "for UR procedures occurring after the date of this opinion where an employer, insurer, or an employee requests UR, a provider which is not a 'health care provider' as defined in the Act, such as a pharmacy, testing facility or provider of medical supplies, must be afforded notice and an opportunity to establish a right to intervene under the usual standards for allowing intervention." *Id.*

Insurer sought reargument with the Commonwealth Court, and the court denied the request. Insurer then filed in this Court a petition for allowance of appeal, which we granted, limited to the following questions as phrased by Insurer: **[**14]**

> (1) Did the Commonwealth Court exceed the scope of its authority and substitute its judgment for that of the Pennsylvania Legislature when it promulgated a new rule which mandates non-healthcare providers are entities with standing and the right to intervene in the Workers' Compensation Act's Utilization Review process?
>
> (2) Did the Commonwealth Court err when it gave non-healthcare providers via the right to void at any time, a Utilization Review Determination regarding the reasonableness and necessity **[*329]** of the care of the physician who wrote the prescription which led to the non-healthcare provider providing a good or service to the injured worker?

Keystone Rx LLC v. Bureau of Workers' Comp. Fee Review Hearing Office, 238 A.3d 338, 339 (Pa. 2020). Hearing Office also sought allowance of appeal, which we granted to address the following issue, as phrased by Hearing Office:

> Whether the Commonwealth Court violated the separation of powers doctrine by engrafting a new requirement onto the Pennsylvania Workers' Compensation Act's process for conducting utilization review of treatment by a health care provider by prospectively directing that non-treating entities be given notice and an opportunity to intervene in utilization reviews?

Id.

Notably, the Commonwealth Court's unconventional, prospective **[**15]** holding

raises a number of potential questions, as evidenced by the above-quoted issues and the parties' various arguments to this Court. To provide a concise analysis regarding the propriety of the Commonwealth Court's reasoning, we find it necessary to characterize the nature of the court's ruling. It appears that, for all intents and purposes, the Commonwealth Court deemed the Act unconstitutional insomuch as it allegedly deprives non-treating providers of due process in UR proceedings. To remedy this perceived infirmity, the court engrafted onto the Act a requirement that non-treating providers must receive notice of and an opportunity to intervene in UR proceedings. We, therefore, will summarize the parties' arguments that align with this understanding of the Commonwealth Court's holding.[4]

Insurer highlights that the Act is an administrative scheme that the Legislature promulgated for the purposes of providing compensation for employees who are injured in the course of their employment and effectuating a workable cost containment system. Insurer maintains that guaranteeing that non-treating providers, such as pharmacies, are paid for filling prescriptions and similar actions **[**16]** does not further either of those purposes. Indeed, Insurer contends that the Act clearly limits non-treating providers who are concerned about payments to fee review proceedings where they may dispute only the "amount or timeliness of the payment from the employer or insurer." 77 P.S. § 531(5). Insurer stresses that the Legislature made these policy decisions and that courts should not disturb these legislative prerogatives.

In addition, Insurer insists that the manner in which the Commonwealth Court decided this case exemplifies that court's recent (alleged) distortion of the Act and its purpose. Specific to this appeal, Insurer contends that the due-process-based rule announced by the court upends 20 years of settled understanding of the function of URs. Insurer warns that, because the court's newly-minted rule entitles non-treating providers to notice and an opportunity to intervene in URs, it necessarily follows that any UR performed without such a providers' participation could be deemed invalid. In Insurer's view, the Commonwealth Court's ruling poses serious threats to the stability of the workers' compensation system. For these reasons, Insurer asks the Court to disavow the **[*330]** Commonwealth Court's **[**17]** prospective holding.

Along the same lines as Insurer's argument, Hearing Office contends that the Legislature created the UR process for the purpose of determining whether a particular medical treatment was reasonable and necessary and that the Legislature deliberately excluded non-treating providers from URs because they do not make any treatment decisions. Hearing Office suggests that the Commonwealth Court strayed from this straightforward reading of the Act and improperly usurped the role of the Legislature in reaching its prospective holding. ***HN5***[⬆] Hearing Office reminds us that this Court recently reiterated the settled concept that "[i]t is axiomatic that [courts] may not add statutory language where [they] find the extant language somehow lacking[.]"[5] Hearing

[4] ***HN4***[⬆] Consideration of the constitutionality of a statute presents a question of law; accordingly, our standard of review is *de novo*, and our scope of review is plenary. *Commonwealth v. Ludwig*, 583 Pa. 6, 874 A.2d 623, 628 n.5 (Pa. 2005).

[5] In any event, Hearing Office opines that the court's decision to violate the separation of powers in this regard was unwise because the dispensing of services or goods that are consistent with a physician's prescription or order, such as Pharmacy's provision of medication prescribed by Physician in this case, has no bearing on the UR process of determining the reasonableness or necessity of the

Office's Brief at 14 (quoting *Sivick v. State Ethics Comm'n*, 238 A.3d 1250, 1264 (Pa. 2020)).

Of significant importance to this appeal, Hearing Office avers that non-treating providers have no recognized property interest as of the time of a UR proceeding because "there is no property interest in payment of the disputed bill before there is a determination that the medical bills are reasonable and necessary." *Id.* at 19 (citing *American Manufacturers Mutual Ins. v. Sullivan*, 526 U.S. 40, 60, 119 S. Ct. 977, 143 L. Ed. 2d 130 (1999)). In this regard, Hearing Office highlights the High Court's **[**18]** holding in *Sullivan* that the Pennsylvania workers' compensation claimants in that case lacked a property interest that would implicate due process until UR proceedings were completed and resulted in a determination that the treatment at issue was reasonable and necessary.

Hearing Office argues that rather than a property interest, Pharmacy has a "mere expectation" of payment until a UR proceeding results in a determination that a given medical treatment is reasonable and necessary. *Id.* at 19 (quoting *Miller v. WCAB (Pavex, Inc.)*, 918 A.2d 809, 812 (Pa. Cmwlth. 2007)). Accordingly, Hearing Office reasons, Pharmacy has not set forth a viable due process claim, and the Commonwealth Court, therefore, violated key separation of powers principles by adding notice and right to intervene elements to the Act for non-treating providers.[6]

Responding to Insurer's arguments, Pharmacy continually refers to its "right to compensation" at the UR phase of **[*331]** workers' compensation proceedings; yet, Pharmacy fails to elaborate adequately on the genesis of that right. Further, Pharmacy insists that the Commonwealth Court did not determine that the UR or fee review provisions of the Act are unconstitutional. Instead, without providing any citation **[**19]** to the Commonwealth Court's opinion and employing a strained interpretation of the Act and its regulations, Pharmacy asserts that the court found the regulations promulgated by the Bureau of Workers' Compensation to be unconstitutional because those regulations deprive due process to non-treating providers by failing to afford them a means to establish their alleged right to payment for services rendered.[7]

Regarding Hearing Office's issue and arguments, Pharmacy observes that non-treating providers have no role in UR proceedings; yet, their right to compensation is entirely dependent on whether the prescriptions they fill are deemed reasonable and necessary during UR proceedings. Pharmacy maintains that because it has an interest in receiving payment for its services, where the UR

---

treatment prescribed by the physician. Hearing Office's Brief at 18.

[6] The following parties filed *amicus curiae* briefs in support of Insurer and Home Office: Coalition Against Insurance Fraud; Laundry Owners Mutual Liability Insurance Association; United Parcel Service; Pennsylvania Chamber of Business and Industry; Insurance Federation of Pennsylvania; American Property Casualty Insurance Association; and National Association of Mutual Insurance Companies.

Each of the *amicus* briefs is similarly structured. They argue that the Commonwealth Court improperly engaged in judicial lawmaking that will lead to severe consequences, such as opening the door to further abuse of a system already plagued by mark-ups of medicines and medical supplies, over prescription, and fraudulent billing practices. *Amici* also emphasize that the Commonwealth Court's new rule will create uncertainty amongst all interested parties, as, *inter alia*, the court used imprecise language regarding whose due process rights entitle them to notice and a right to intervene, which will lead to protracted appellate litigation.

[7] In reality, the Commonwealth Court made direct reference to a Bureau regulation in its opinion only once in a footnote. *Keystone Rx*, 223 A.3d at 297 n.4. The court made this lone reference to underscore that both the Act and its regulations allow only employees, employers, and insurers to request UR.

regulations authorize review of services of non-treating providers, UR regulations "must also allow those non-treating providers to have notice and a right to participate, just as they do for treatment provided by a healthcare provider." Pharmacy's Brief at 31. Pharmacy argues that the UR regulations are constitutionally repugnant for violating due process, and thus, the Commonwealth Court did not violate separation **[**20]** of powers principles by interpreting the Act in a way that vindicates non-treating providers' right to due process.

Regarding the United States Supreme Court's holding in *Sullivan*, Pharmacy suggests that *Sullivan* concerned the due process rights of treating providers, who are clearly part of UR proceedings. Pharmacy emphasizes that it had no right to participate in UR proceedings, distinguishing this case from *Sullivan*. For these reasons, Pharmacy believes that this Court should uphold the Commonwealth Court's decision.

HN6[⬆] To the extent that the Commonwealth Court deemed the Act to be unconstitutional, we note that every piece of legislation passed by the General Assembly enjoys the strong presumption that it is constitutional. *Pennsylvania State Ass'n of Jury Comm'rs v. Com.*, 619 Pa. 369, 64 A.3d 611, 618 (Pa. 2013). Thus, "a party challenging the constitutionality of a statute bears a very heavy burden of persuasion." *Stilp v. Com.*, 588 Pa. 539, 905 A.2d 918, 939 (Pa. 2006). Indeed, a court will not deem a legislative enactment unconstitutional unless it clearly, palpably, and plainly violates the Constitution. *Id.* "If there is any doubt that a challenger has failed to reach this high burden, then that doubt must be resolved in favor of finding the statute constitutional." *Pennsylvania State Ass'n of Jury Comm'rs*, 64 A.3d at 618.

HN7[⬆] The Fourteenth Amendment to the United States Constitution provides that no State may "deprive any person of life, liberty, or property, **[**21]** without due process of law[.]" U.S. CONST., amend. XIV. The first inquiry in every due process challenge is whether the [complaining party] has been deprived of a protected interest in 'property' or 'liberty.'" *Sullivan*, 526 U.S. at 59. Here, the Commonwealth Court seemingly found that the Act fails to **[*332]** provide non-treating providers with sufficient process to defend their alleged protected property interest in receiving payment pursuant to the Act. Indeed, the Commonwealth Court, in effect, found the Act to be constitutionally deficient because it does not afford non-treating providers with appropriate procedural due process, the fundamental hallmarks of which are notice and an opportunity to be heard. *See Friends of Danny DeVito v. Wolf*, 227 A.3d 872, 896 n.16 (Pa. 2020) (describing the hallmarks of procedural due process).[8] For the reasons that follow, we respectfully disagree.

HN9[⬆] In so doing, we first observe that the Act clearly and unambiguously provides that employers and insurers are obligated to pay providers, such as Pharmacy, for reasonable and necessary treatment or services connected to claimants' work-related injuries. 77 P.S. § 531(1)(i) ("The employer shall provide payment in accordance with this section for reasonable surgical and medical services,

---

[8] To the extent that we must interpret the Act in this appeal, that task is guided by the Statutory Construction Act, 1 Pa.C.S. §§ 1501-1991. ***HN8***[⬆] Pursuant to the Statutory Construction Act, the object of all statutory construction is to ascertain and effectuate the General Assembly's intention. 1 Pa.C.S. § 1921(a). When the words of a statute are clear and free from ambiguity, the letter of the statute is not to be disregarded under the pretext of pursuing its spirit. 1 Pa.C.S. § 1921(b).

services rendered by physicians or other health care **[**22]** providers, including an additional opinion when invasive surgery may be necessary, medicines and supplies, as and when needed."); *id.* at § 531(5) ("The employer or insurer shall make payment . . . in accordance with the provisions of this section."). Indeed, the Act mandates that employers or insurers pay providers within 30 days of the receipt of bills; however, that obligation is, at least temporarily, eliminated if employers or insurers dispute the reasonableness or necessity of the treatment at issue. *Id.* ("All payments to providers for treatment provided pursuant to this act shall be made within thirty (30) days of receipt of such bills and records unless the employer or insurer disputes the reasonableness or necessity of the treatment provided pursuant to paragraph (6)[, which addressed UR]."). ***HN10***[⬆] In other words, if an employer or insurer triggers the UR mechanism for challenging the reasonableness or necessity of treatment, then the employer or insurer is not obligated to pay for the treatment unless the UR results in a determination that the treatment at issue was reasonable and necessary.

HN11[⬆] Thus, when a non-treating provider bills an insurer and the insurer invokes the UR process, the non-treating provider **[**23]** is not entitled to payment under the Act. Further, if the UR results in a determination that the treatment at issue is unreasonable or unnecessary, the employer and insurer are not liable under the Act to pay for the treatment. *See Sullivan*, 526 U.S. at 60 (citing, *inter alia*, 77 P.S. § 531(1)(i) and opining that the Act "expressly limits an employee's entitlement to 'reasonable' and 'necessary' medical treatment, and requires that disputes over the reasonableness and necessity of particular treatment must be resolved *before* an employer's obligation to pay—and an employee's entitlement to benefits—arise.")[9] (emphasis in original). On the other hand, if a UR results in a conclusion that the treatment was reasonable and necessary, then the non-treating provider is entitled to payment under the Act and has the fee review process to **[*333]** litigate the amount or timeliness of the payment from the employer or insurer.

HN12[⬆] Accordingly, when, as here, an insurer successfully challenges a treatment, the Act makes clear that a non-treating provider does not have a constitutionally-protected property interest in goods or services that it dispensed, as these providers were never entitled to payment under the Act; rather, they simply have an expectation **[**24]** of payment in the normal course. Absent a constitutionally protected property interest, there is no viable due process claim. Thus, the Commonwealth Court erred by concluding that the Act improperly fails to account for the due process rights of non-treating providers in UR proceedings and by engrafting onto the Act a requirement that non-treating providers receive notice of and an opportunity to intervene in UR proceedings. We, therefore, reject that portion of the court's opinion but otherwise affirm the court's order.[10]

Justices Saylor, Todd, Donohue, Dougherty, Wecht and Mundy join the opinion.

Justice Wecht files a concurring opinion in which Justice Dougherty joins.

---

[9] Any issue concerning other remedies possibly available to non-treating providers to collect for goods or services rendered is not currently before the Court.

[10] Given our conclusion, we need not address the Commonwealth Court's decision in *Armour*. We nonetheless note that we are satisfied with the manner in which the Commonwealth Court distinguished the instant matter from the circumstances underlying *Armour*. *See*, *supra*, at 7.

Concur by: WECHT

Concur

JUSTICE WECHT

I join the Majority Opinion in full.

Today's disposition reflects the judiciary's obligation to defer to the legislature's policy choices. Remedies may be available to aggrieved providers like Keystone Rx that have been left out of the Utilization Review process of the Workers' Compensation Act, but these remedies do not include judicial re-writing of the Act.

Under the Act, Utilization Review allows employers, employees, and insurers to obtain an impartial determination of the "reasonableness **[**25]** or necessity" of a claimant's treatment. 77 P.S. 531(6)(i). After that initial determination, a party or a health care provider has the right to seek review. *Id.* § 531(6)(iv). This process examines the medical treatment under review, including services provided by non-treating providers, such as Keystone Rx, which dispensed medications pursuant to a physician's prescription. Such non-treating providers are not, however, included in the process.

The legislature could have included non-treating providers in the Utilization Review process. It did not do so. Instead, the General Assembly provided a remedy to non-treating providers that is limited to challenging the amount and timeliness of payment for treatment that is reasonable and necessary. *See* Maj. Op. at 15-16; *see also* 77 P.S. § 531(1)(i). The process for determining the reasonableness and necessity of treatment affords no role for non-treating providers, essentially shifting the cost of rendering treatment that is later determined not to be reasonable or necessary from the insurer or employer to the non-treating provider.

This scheme was legislated by the General Assembly. The legislature exercised its policy-making authority to decide who should be included in Utilization Review, **[**26]** and who should not. This is the function of our General Assembly: it makes social policy judgments and decides among competing interests. *Villani v. Seibert*, 639 Pa. 58, 159 A.3d 478, 492 (Pa. 2016) ("[T]his Court frequently acknowledges the Legislature's superior resources and institutional prerogative **[*334]** in making social policy judgments upon a developed analysis."); *Weaver v. Harpster*, 601 Pa. 488, 975 A.2d 555, 563 (Pa. 2009) ("[I]t is for the legislature to formulate the public policies of the Commonwealth."). Whatever the potential inequity of this result, it is a matter of legislative discretion. It is not a field for judicial reformation.

It is not for the judiciary to usurp the General Assembly's policy-making authority and exceed the parameters of legislation by engrafting statutory requirements that the General Assembly chose to omit, even where sound reasons may appear to favor the creation of a mechanism omitted from the statute.[1] *Discovery Charter Sch. v. Sch. Dist. of Phila*, 641 Pa. 136, 166 A.3d 304, 318 (Pa.

---

[1] Of course, legislation cannot deprive any person of a protected property interest without due process of law. *See Am. Mfrs. Mutual Ins. v. Sullivan*, 526 U.S. 40, 59, 119 S. Ct. 977, 143 L. Ed. 2d 130 (1999). As the Majority observes, there is no protected property interest in the payment of disputed medical bills before the treatment is deemed reasonable and necessary. *See* Maj. Op. at 15-16. Although Keystone Rx may have had an expectation of payment for prescriptions it dispensed, it had no protected property interest in those payments, and due process protections do not apply to mere expectations. *See id.* at 16.

2016) ("[I]t is not the province of the judiciary to augment the legislative scheme."); *Parker v. Children's Hosp. of Phila.*, 483 Pa. 106, 394 A.2d 932, 937 (Pa. 1978) ("[T]he power of judicial review must not be used as a means by which the courts might substitute its judgment as to public policy for that of the legislature."); *Glancey v. Casey*, 447 Pa. 77, 288 A.2d 812, 816 (Pa. 1972) ("Time and again, we have taken the position that the judiciary does not question the [w]isdom of the action of a legislative **[**27]** body.").

Because it was the legislature that, by design, made payment to non-treating providers contingent upon determinations of reasonableness and necessity, the remedy for the consequences of this decision also lies with the legislature. Entities left out of the Utilization Review process—including diagnostic testing facilities, durable medical equipment companies, laboratories, medical imaging centers, opticians, pharmacies, physical therapy centers, and visiting nurses—are free to petition the legislature for redress for payment for services rendered under a physician's orders. Keystone Rx's policy-based arguments are for the policy-making branches. They are not for the judiciary.

Short of legislative intervention, non-treating providers will have to make the business decision of whether to continue providing services to workers' compensation claimants. Perhaps a reasonable business decision would be to eliminate the risk by refusing to fill prescriptions in workers' compensation cases, knowing and opting out of the risks involved in such transactions. As this case comes to us, however, Keystone Rx assumed the risk when it entered into its business, knowing the limitations **[**28]** involved, and elected to fill prescriptions for workers' compensation claimants whose treatment may ultimately prove non-compensable under the Act.

Non-treating providers might opt to continue providing services and spread the risk of non-payment, insure against it, or seek subrogation or payment from another insurer as the facts and circumstances may allow. Perhaps these providers might choose to pursue remedies directly against the injured workers. Although an injured employee is not responsible under the Act for reasonable and necessary treatment resulting from a work-related injury, it does not appear that any law precludes direct action against a customer whose injuries are not compensable under the Act. Where the Act is not implicated, any remedies Keystone Rx would have generally **[*335]** against its customers would presumably be available, including a breach of contract claim. Any argument that the Act or the accompanying regulations preclude directly billing an injured employee fall away once the injury or treatment is determined not to be compensable under the Act.[2]

Non-treating providers are free to re-calibrate their businesses to adjust to the legislature's decision **[**29]** to impose upon them the risk

---

[2] *See, e.g.*, 77 P.S. § 531(7) ("A provider shall not hold an employe liable for costs related to care or service rendered in connection with a compensable injury under this act. A provider shall not bill or otherwise attempt to recover from the employe the difference between the provider's charge and the amount paid by the employer or the insurer."). Although the Bureau of Workers' Compensation's regulations prohibit balance billing, this prohibition pertains to "providers," which is regulatorily defined as "health care

Justice Dougherty joins this concurring opinion. providers." *See* 34 PA. CODE § 127.211(b) ("A provider may not bill for, or otherwise attempt to recover from the employe, charges for treatment or services determined to be unreasonable or unnecessary in accordance with the act or Subchapter C (relating to medical treatment review)."); *id.* § 127.3 (defining "provider" to mean a "health care provider"). Because Keystone Rx has never identified itself as a health care provider, this regulatory prohibition is inapplicable.

of non-payment for treatment that is later determined not to be reasonable or necessary. But we are not free to recalibrate the statutory law.

Omni Pharm. Servs., LLC v. Bureau of Workers' Comp. Fee Review Hearing Office (Am. Interstate Ins. Co.)

Commonwealth Court of Pennsylvania

September 15, 2020, Submitted; October 30, 2020, Decided; October 30, 2020, Filed

No. 1333 C.D. 2019

Reporter
241 A.3d 1273 *; 2020 Pa. Commw. LEXIS 724 **; 2020 WL 6370327

Omni Pharmacy Services, LLC, Petitioner v. Bureau of Workers' Compensation Fee Review Hearing Office (American Interstate Insurance Company), Respondent

Subsequent History: Rehearing denied by Omni Pharm. Servs., LLC v. Bureau of Workers' Comp. Fee Review Hearing Office (Am. Interstate Ins. Co.), 2020 Pa. Commw. LEXIS 806 (Pa. Commw. Ct., Dec. 18, 2020)

Prior History: [1]** Appealed from No. DSP-7986636-1. Bureau of Workers' Compensation.

Case Summary

Overview
HOLDINGS: [1]-The determination vacating direction to an employer to pay a pharmacy's invoices for a compound cream used by an injured worker was vacated because if the compound cream was prescribed for a medical problem that was not work-related, a fortiori it was not reasonable or necessary for treatment of the accepted work injury, thus, a remand was necessary for the Hearing Office to adjudicate on the merits of the employer's appeal of the fee review determination; [2]-The court held that how an employer's liability was established was irrelevant; rather, what was relevant was that if the employer accepted liability for the claimant's work injury, whether the compound cream prescribed to the claimant constituted reasonable and necessary treatment for the accepted work injury.

Outcome
Order vacated; case remanded to of the Hearing Office.

LexisNexis® Headnotes

Administrative Law > Judicial Review > Standards of Review > Constitutional Right

Civil Procedure > Appeals > Standards of Review > De Novo Review

HN1[] **Standards of Review, Constitutional Right**

The Commonwealth Court of Pennsylvania's review in medical fee review cases determines whether constitutional rights were violated, whether an error of law was committed, or whether the necessary findings of fact were supported by substantial evidence. Regarding questions of law, the court's scope of review is plenary and its standard of review is de novo.

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized

Treatment

HN2[] **Medical Benefits, Authorized Treatment**

The Workers' Compensation Act, 77 Pa. Stat. Ann. §§ 1-1041.4, 2501-2710, requires employers to make prompt payment on provider invoices for reasonable and necessary medical treatment of a claimant's work injury, and it establishes procedures for resolving disputes between a provider and an employer about whether the treatment actually meets that standard.

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

HN3[] **Medical Benefits, Authorized Treatment**

As does Section 306(f.1)(6) of the Workers' Compensation Act, 34 Pa. Code § 127.406(a), the Department of Labor and Industry's cost containment regulation states that utilization review decides the reasonableness or necessity of the treatment. That regulation also states that utilization review does not decide the causal relationship between the treatment under review and the employe's work-related injury. 34 Pa. Code §127.406(b)(1). Finally, the regulation states that in medical only cases, when an insurer is paying for an injured worker's medical treatment but has not admitted liability for a work-related injury, the insurer may still seek review of the reasonableness or necessity of the treatment by filing a request for utilization review. 34 Pa. Code § 127.405(a).

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

HN4[] **Medical Benefits, Authorized Treatment**

The regulation states that utilization review determines whether treatment for an accepted work injury is reasonable or necessary, but it does not determine the causal relationship between the treatment under review and the work injury. 34 Pa. Code § 127.406(a), (b)(i).

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

HN5[] **Medical Benefits, Authorized Treatment**

Where the existence of a work injury or its scope are disputed, then cause is beyond utilization review. However, once the work injury is established, the reasonableness or necessity of treatment must be determined in utilization review, not in a claim petition proceeding. This is a statutory requirement. 77 Pa. Stat. Ann. § 531(6).

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

HN6[] **Medical Benefits, Authorized Treatment**

Where an employer challenges a provider's treatment as neither reasonable nor necessary for a work injury, it may seek utilization review pursuant to Section 306(f.1)(6) of the Act, 77 Pa. Stat. Ann. § 531(6). Until the utilization review is completed, the employer may suspend payment to the provider. 77 Pa. Stat. Ann. § 531(5). Where a provider does not receive payment within 30 days (and payment has not been stayed by an employer's utilization review request), the provider may file a fee review petition pursuant to Section 306(f.1)(5) of the Act, 77 Pa. Stat. Ann. § 531(5).

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

HN7[] **Medical Benefits, Authorized Treatment**

Whether a claimant has sustained a work injury and the scope of that work injury are questions that must be litigated in a claim petition proceeding. A fee review proceeding is not the mechanism for establishing the existence and precise scope of a work injury. The fee review process presupposes that liability has been established, either by voluntary acceptance by the employer or a determination by a Workers Compensation Judge. Neither the Act nor the medical cost containment regulations provide any authority for a fee review officer to decide the issue of liability in a fee review proceeding. 34 Pa. Code §127.255(1) states that an application for fee review filed by a provider is premature and will be returned if the insurer denies liability for the alleged work injury. The issue for the fee review officer is the amount and timeliness of the payment made by an insurer. 34 Pa. Code § 127.251. Accordingly, a fee review petition is premature in the following instances:(1) The insurer denies liability for the alleged work injury. The insurer has filed a request for utilization review of the treatment under Subchapter C, relating to medical treatment review. The 30-

day period allowed for payment has not yet elapsed, as computed under 34 Pa. Code § 127.208, relating to time for payment of medical bills. 34 Pa. Code § 127.255.

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

HN8[] **Medical Benefits, Authorized Treatment**

The Commonwealth Court of Pennsylvania has explained that once liability for a work injury has been established, the employer may file a modification petition to change the scope of the accepted injury or it can seek utilization review, which stays the 30-day deadline to pay a provider's invoice. A claimant may be under treatment for an array of medical problems, only some of which relate to the work injury. It is for the Utilization Review Organization to sort this out.

Business & Corporate Compliance > ... > Contracts Law > Types of Contracts > Releases

Workers' Compensation & SSDI > Administrative Proceedings > Settlements

HN9[] **Types of Contracts, Releases**

How an employer's liability is established is irrelevant. Liability can be established by a compromise and release agreement, in a Notice of Compensation Payable, or in an adjudication by a Workers Compensation Judge.

Counsel: Daniel J. Siegel, Havertown, for Petitioner.

Andrew W. Maffett, Harrisburg, for Respondent.

Judges: BEFORE: HONORABLE MARY HANNAH LEAVITT, President Judge, HONORABLE PATRICIA A. McCULLOUGH, Judge, HONORABLE ELLEN CEISLER, Judge. OPINION BY PRESIDENT JUDGE LEAVITT.

Opinion by: MARY HANNAH LEAVITT

Opinion

[*1274] OPINION BY PRESIDENT JUDGE LEAVITT

Omni Pharmacy Services, LLC, (Pharmacy) petitions for review of an adjudication of the Bureau of Workers' Compensation (Bureau), Fee Review Hearing Office (Hearing Office), that vacated three determinations of the Bureau's Medical Fee Review Section. At issue are Pharmacy's invoices for compound creams that it dispensed to Charles Gilbert (Claimant) for treatment of a work injury, which Stitzer Crane Services, Inc./American Interstate Insurance Company (Employer) refused to pay. When the Medical Fee Review Section directed Employer to pay Pharmacy's invoices, Employer appealed. The Hearing Office held that Pharmacy's fee review petition was premature; dismissed Employer's appeal of the determination of the Medical Fee Review Section for lack of jurisdiction; and vacated the determinations of the Medical Fee Review Section **[**2]** directing Employer to pay Pharmacy's invoices for the compound creams.

Before this Court, Pharmacy asserts that the Hearing Office erred. Pharmacy contends that its fee review petition was appropriate because Employer has acknowledged Claimant's work injury. If Employer believed the compound creams were not reasonable and necessary to treat Claimant's work injury, it should have sought utilization review. Because Employer did not do so, Pharmacy contends that its fee review petition was not premature.

I. Background

On September 19, 2017, Claimant sustained a work injury in the nature of a left ankle fracture.[1] To treat Claimant's pain, Bradley Barter, D.O., prescribed a compound cream consisting of transdermal pain base cream, amitriptyline, diclofenac, gabapentin, lidocaine and baclofen.[2] Reproduced Record at 12a (R.R. __). Claimant was instructed to apply the compound cream to the "affected area" two to four times a day, as needed. *Id.*

Pharmacy dispensed the compound cream to Claimant on

[1] The existence of Claimant's accepted work injury is not contested.

[2] There were two prescriptions, dated February 8, 2018, and April 26, 2018, for the identical compound cream.

May 24, 2018, June 21, 2018, and July 19, 2018.[3] Pharmacy submitted invoices to Employer in the amount of $6,081.09 for all three transactions; the invoices contained the following information:

- Date of **[**3]** Service
- Names of the drugs/medications
- NDC [National Drug Code] numbers for all components of the medication
- Prescribing Physician

[*1275] • Prescription number
- Diagnosis Code
- Date of Injury
- Itemized and total amount due.

R.R. 10a-11a, 19a-20a, 78a-79a.

Employer denied payment of all three invoices, stating it was not liable for the treatments.[4] Adjudication at 3, F.F. No. 6. Pharmacy then filed fee review applications with the Medical Fee Review Section. After review, the Medical Fee Review Section issued determinations in favor of Pharmacy on all three fee review applications. It directed Employer to pay repriced invoices in the amount of $4,827.56, plus interest at the rate of 10% *per annum*, calculated from the date payment on each bill was due. R.R. 35a, 43a, 85a.

Employer requested hearings to contest the three determinations of the Medical Fee Review Section. The Hearing Office consolidated the hearings. At the hearing, Employer stated that Pharmacy's "bills have been denied on the issue of causation." Notes of Testimony, 11/28/2018, at 8 (N.T. __); R.R. 27a. Employer asked the Hearing Office to "divest itself of jurisdiction" of Employer's requested hearing for the stated reason that causation "must **[**4]** be determined by a Workers' Compensation Judge [(WCJ).]" N.T. 8; R.R. 27a. Pharmacy argued that Employer asserted its causation issue without presenting any evidence that the compound cream was not prescribed for treatment of Claimant's work injury. Neither Employer nor Pharmacy presented testimonial evidence.

The Hearing Office concluded "that there is a dispute between [Employer and Pharmacy] pertaining to the causal relationship of the prescribed compound cream and the accepted work injury." Adjudication at 6, F.F. No. 20. Based on that conclusion, the Hearing Office dismissed Employer's request for a hearing for the stated reason that it lacked jurisdiction. It then vacated the three fee review determinations of the Medical Fee Review Section directing Employer to pay Pharmacy's invoices.

II. Appeal

Pharmacy has petitioned for this Court's review,[5] asserting that the Hearing Office erred. Employer has accepted liability for Claimant's work injury, but it did not seek utilization review of the compound creams as neither reasonable nor necessary to treat Claimant's work injury. Pharmacy contends our recent decision in *Workers' First Pharmacy Services, LLC v. Bureau of Workers' Compensation Fee Review Hearing Office (Gallagher Bassett Services)*, 225 A.3d 613 (Pa. Cmwlth. 2020), requires this Court to reverse the Hearing Office's determination that it lacked **[**5]** jurisdiction.

III. Discussion

We begin with a review of the relevant provisions of the Workers' Compensation Act (Act).[6] ***HN2***[] It requires employers to make prompt payment on provider invoices for **[*1276]** reasonable and necessary medical treatment of a claimant's work injury, and it establishes procedures for resolving disputes between a provider and an employer about whether the treatment actually meets that standard. Specifically, Section 306(f.1)(5) of the Act states:

> The employer or insurer shall make payment and providers shall submit bills and records in accordance with the provisions of this section. *All payments to providers for treatment provided pursuant to this act shall be made within thirty (30) days of receipt of such bills and records unless the employer or insurer disputes*

[3] Pharmacy filed an additional application for fee review for a compound cream dispensed to Claimant on April 26, 2018. The Hearing Office concluded that application was not before it. Adjudication at 5, Finding of Fact (F.F.) No. 12, n.4.

[4] Employer's denial of the invoice for the June 21, 2018, cream was not entered into evidence.

[5] ***HN1***[] Our review in medical fee review cases determines whether constitutional rights were violated, whether an error of law was committed, or whether the necessary findings of fact were supported by substantial evidence. *Pittsburgh Mercy Health System v. Bureau of Workers' Compensation, Fee Review Hearing Office (US Steel Corporation)*, 980 A.2d 181, 184 n.4 (Pa. Cmwlth. 2009). Regarding questions of law, our scope of review is plenary and our standard of review is *de novo*. *Sedgwick Claims Management Services, Inc. v. Bureau of Workers' Compensation, Fee Review Hearing Office (Piszel and Bucks County Pain Center*), 185 A.3d 429, 433 n.2 (Pa. Cmwlth. 2018).

[6] Act of June 2, 1915, P.L. 736, *as amended*, 77 P.S. §§1-1041.4, 2501-2710.

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

77 P.S. §531(5) (emphasis added). "Paragraph 6" of Section 306(f.1) states, in relevant part, as follows:

> *[D]isputes as to reasonableness or necessity of treatment by a health care provider shall be resolved in accordance with the following provisions*:
>
> > (i) The reasonableness or necessity of all treatment provided by a health care provider under this act may be subject to prospective, concurrent or retrospective utilization review at the request of an employe, employer or insurer. The department shall authorize utilization review organizations **[**7]** to perform utilization review under this act. Utilization review of all treatment rendered by a health care provider shall be performed by a provider licensed in the same profession and having the same or similar specialty as that of the provider of the treatment under review.

77 P.S. §531(6)(i) (emphasis added).

HN3[] As does Section 306(f.1)(6) of the Act, the Department of Labor and Industry's cost containment regulation states that utilization review decides the "reasonableness or necessity of the treatment[.]" 34 Pa. Code §127.406(a). That regulation also states that utilization review does "not decide" the "causal relationship between the treatment under review and the employe's work-related injury." 34 Pa. Code §127.406(b)(1).[7] Finally, the regulation **[*1277]** states that "[i]n medical only cases, when an insurer is paying for an injured worker's medical treatment" but has not admitted liability for a work-related injury, "the insurer may still seek review of the reasonableness or necessity of the treatment by filing a request for [utilization review]." 34 Pa. Code §127.405(a).

HN6[] In sum, where an employer challenges a provider's treatment as neither reasonable nor necessary for a work injury, it may seek utilization review pursuant to Section 306(f.1)(6) of the Act, 77 P.S. §531(6). Until the utilization review is completed, **[**8]** the employer may "suspend payment to the provider." 77 P.S. §531(5). Where a provider does not receive payment within 30 days (and payment has not been stayed by an employer's utilization review request), the provider may file a fee review petition pursuant to Section 306(f.1)(5) of the Act, 77 P.S. § 531(5).

HN7[] Whether a claimant has sustained a work injury and the scope of that work injury are questions that must be litigated in a claim petition proceeding. *Inglish House, Appellant, v. Workmen's Compensation Appeal Board (Reedy), Appellee*, 535 Pa. 135, 634 A.2d 592, 595 (Pa. 1993). A fee review proceeding is not the mechanism for establishing the existence and precise scope of a work injury. As this Court has explained,

> the fee review process *presupposes* that liability has been established, either by voluntary acceptance by the employer or a determination by a WCJ. Neither the Act nor the medical cost containment regulations provide any authority for a fee review officer to decide the issue of liability in a fee review proceeding. *The Department's regulations, at 34 Pa. Code §127.255(1), state that an application for fee review filed by a provider is premature and will be returned if "[t]he insurer denies liability for the alleged work injury*." The issue for the fee review officer is the "amount and timelines[s] of the payment made by an insurer." 34 Pa. Code § 127.251.

---

[7] ***HN4***[] The regulation states that utilization review determines whether treatment for an accepted work injury is "reasonable or necessary," but it does not determine the "causal relationship between the treatment under review" and the work injury. 34 Pa. Code §127.406(a), (b)(i). There is some ambiguity in the regulation. ***HN5***[] Where the existence of a work injury or its scope are disputed, then "cause" is beyond utilization review. However, once the work injury is established, the "reasonableness or necessity" of treatment must be determined in utilization review, not in a claim petition proceeding. This is a statutory requirement. Section 306(f.1)(6) of the Act, 77 P.S. §531(6).

Nickel v. Workers' Compensation Appeal Board (Agway Agronomy), 959 A.2d 498, 503 (Pa. Cmwlth. 2008) (emphasis added). Accordingly, **[**9]** a fee review petition is premature in the following instances:

> (1) The insurer denies liability for the alleged work injury.
>
> (2) The insurer has filed a request for utilization review of the treatment under Subchapter C (relating to medical treatment review).
>
> (3) The 30-day period allowed for payment has not yet elapsed, as computed under § 127.208 (relating to time for payment of medical bills).

34 Pa. Code §127.255.

In *Workers' First Pharmacy*, 225 A.3d at 615, the employer contested liability for a compound cream, arguing that the treatment was inconsistent with the claimant's accepted work injury, *i.e.*, a right shoulder strain. The work injury was accepted pursuant to a compromise and release (C&R) agreement, and the employer agreed to pay all medical bills related to the accepted work injury. However, the C&R agreement did not specify that the compound cream was related to the accepted work injury.

The Hearing Office found that liability for the compound cream had to be established either by the employer's acceptance of liability or by the WCJ in a claim petition proceeding. Because the C&R agreement did not state that the compound cream was related to the work injury, liability was not established. As such, the pharmacy's fee review petition was dismissed **[**10]** as premature. The pharmacy appealed, and we reversed the Hearing Office.

We rejected the employer's argument that its liability for the compound cream had to be established in a claim petition **[*1278]** proceeding where the employer had accepted liability for the work injury. The "sole question [was] whether the compound cream was reasonable and necessary for treatment of the accepted work injury. This is an issue for utilization review." *Id.* at 621.

HN8[] We explained that once liability for a work injury has been established, the employer may file a modification petition to change the scope of the accepted injury or it can seek utilization review, which stays the 30-day deadline to pay a provider's invoice. A claimant "may be under treatment for an array of medical problems, only some of which relate to the work injury. It is for the Utilization Review Organization to sort this out." *Id.* at 620-21. Stated otherwise, if the compound cream was prescribed for a medical problem that is not work-related, "*a fortiori* it is not reasonable or necessary for treatment of [the] accepted work injury." *Id.* at 621. Accordingly, we vacated the adjudication and remanded the matter to the Hearing Office for an adjudication on the merits of the employer's **[**11]** appeal of the fee review determination.

Pharmacy argues that the facts in this case are identical to *Workers' First Pharmacy*. Here, as in *Workers' First Pharmacy*, Employer accepted liability for a work injury; Employer denied reimbursement to Pharmacy for the stated reason that the compound cream was not causally related to the work injury; Pharmacy filed fee review applications; and Employer did not request utilization review.

Employer argues that *Workers' First Pharmacy* is distinguishable because it involved a C&R agreement. We disagree. ***HN9***[] How an employer's liability is established is irrelevant. Liability can be established by a C&R agreement, in a Notice of Compensation Payable, or in an adjudication by a WCJ. What is relevant is that, here, Employer accepted liability for Claimant's work injury. As in *Workers' First Pharmacy*, Employer is challenging whether the compound cream prescribed to Claimant constituted reasonable and necessary treatment for the accepted work injury. Simply, "[i]f the compound cream was prescribed for a non-work-related injury of [the claimant], *a fortiori* it is not reasonable or necessary for treatment of [the] accepted work injury." *Id.* at 621.

For these reasons, we **[**12]** vacate the adjudication of the Hearing Office and remand this matter for a decision on the merits of the fee review determinations.

MARY HANNAH LEAVITT, President Judge

ORDER

AND NOW, this 30th day of October, 2020, the order of the Bureau of Workers' Compensation Fee Review Hearing Office, dated August 27, 2019, is hereby VACATED, and this matter is REMANDED for further proceedings in accordance with the attached opinion.

Jurisdiction relinquished.

MARY HANNAH LEAVITT, President Judge

Rodriguez v. Workers' Comp. Appeal Bd. (Adecco Grp. N. Am.)

Commonwealth Court of Pennsylvania

November 22, 2019, Submitted; January 6, 2021, Decided; January 6, 2021, Filed

No. 869 C.D. 2019

Reporter
2021 Pa. Commw. Unpub. LEXIS 5 *; ***247 A.3d 1180***

Daisy A. Rodriguez, MD, Petitioner v. Workers' Compensation Appeal Board (Adecco Group North America), Respondent

Judges: BEFORE: HONORABLE P. KEVIN BROBSON, Judge[1] **[*1]** , HONORABLE MICHAEL H. WOJCIK, Judge, HONORABLE BONNIE BRIGANCE LEADBETTER, Senior Judge.

Opinion by: MICHAEL H. WOJCIK

Opinion

MEMORANDUM OPINION BY JUDGE WOJCIK

Daisy A. Rodriguez, MD (Provider) petitions for review of the June 14, 2019 order of the Workers' Compensation Appeal Board (Board), which reversed the decision of a workers' compensation judge (WCJ) granting Provider's penalty petition for lack of evidence. Upon review, we affirm on other grounds.

John Irons (Claimant) was employed by Adecco Group North America (Employer) as a warehouse worker. On January 6, 2015, Claimant was injured during the course and scope of his employment when he slipped and fell on snow on Employer's premises.

Employer issued a notice of temporary compensation payable (NTCP) describing the injury as a strain/sprain of the low back and left knee. On January 21, 2015, Claimant filed a claim petition alleging that, in addition to injuring his back and knee, he also injured his neck and suffered from post-concussion syndrome and headaches. Claimant alleged ongoing total disability. Employer filed an answer denying that Claimant sustained injuries other than those already acknowledged **[*2]** in the NTCP.

On February 24, 2015, Employer issued a notice stopping temporary compensation along with a medical-only notice of compensation payable (NCP) accepting liability for the medical bills for a strain/sprain of the low back and left knee but not wage loss benefits. Reproduced Record (R.R.) at 68a. On May 8, 2015, Employer filed a termination petition alleging that Claimant fully recovered from his work injury as of April 8, 2015. Employer did not file a utilization review request at any time.

---

[1] The decision in this case was reached prior to January 4, 2021, when Judge Brobson became President Judge.

During that litigation, Claimant submitted evidence including the testimony of Provider. On February 4, 2016, WCJ Lawrence denied Claimant's claim petition, finding that Claimant did not sustain any other injuries in addition to the strain/sprain of the low back and left knee, and did not experience wage loss due to the work injury because Employer made work available to Claimant. WCJ Lawrence rejected Provider's testimony as not credible. WCJ Lawrence granted Employer's termination petition, finding that Claimant had fully recovered from his work injury as of April 8, 2015. Claimant appealed to the Board, which affirmed WCJ Lawrence's decision on December 2, 2016. R.R. at 71a-82a.

On June 26, 2017, **[*3]** Provider filed the instant penalty petition, alleging that Employer violated the Workers' Compensation Act (Act)[2] by issuing the medical-only NCP accepting as compensable low back and left knee injuries but failing to pay medical bills related to those injuries up to WCJ Lawrence's February 4, 2016 decision and order terminating Claimant's benefits. R.R. at 6a-9a. Employer filed an answer denying that it violated the Act and averring that Provider was seeking payment for treatments not causally related to the work injury as found by WCJ Lawrence. *Id.* at 13a.

On December 20, 2017, WCJ DiLorenzo granted Provider's penalty petition, concluding that Employer violated the Act by failing to pay Provider for medical treatment rendered to Claimant from April 8, 2015, up until February 4, 2016, when WCJ Lawrence terminated Claimant's benefits. R.R. at 16a-24a. WCJ DiLorenzo found that Employer was not required to pay for treatment from January 7, 2015, through April 7, 2015, because Provider was not a panel provider. *Id.* WCJ DiLorenzo declined to assess a penalty, but ordered Employer to pay $39,341.93 for medical expenses and to reimburse Provider's litigation costs. *Id.* Employer appealed to the Board. *Id.* at 25a-29a. **[*4]**

On appeal, the Board reversed. The Board found that

> WCJ [DiLorenzo] erred in granting [Provider's penalty petition] by ordering [Employer] to pay medical bills up to February 4, 2016, in the amount of $39,341.93. An employer is only responsible to pay for medical expenses that are causally related to the recognized work injury. Moreover, if a medical provider disputes the amount or timeliness of payments, the provider "shall file an application for fee review." Section 306 of the Act, 77 P.S. §531(5).

Board Opinion at 7. Provider now petitions this Court for review.[3]

Provider first argues that the Board erred in holding that she must file an application for fee review prior to filing a penalty petition. Second, Provider argues that the Board exceeded its scope of review by making its own credibility determinations and weighing evidence.

Employer argues that the Board correctly held that WCJ DiLorenzo's decision was not supported by substantial evidence. Employer argues that the Board properly determined Provider should have availed herself of the fee review process under the Act prior to filing a penalty petition. However, Employer asserts that the Board's decision ultimately rests on the lack of causal relation **[*5]** of the billed treatments to Claimant's work injury.

Section 306(f.1)(1)(i) of the Act requires the employer to pay for "reasonable surgical and medical services, services rendered by physicians or other health care providers . . . as and when needed." 77 P.S. §306(f.1)(1)(i). Section 306(f.1)(5) of the Act provides, in relevant part:

> A provider who has submitted the reports and bills required by this section and who disputes the *amount or timeliness* of payment from the employer or insurer *shall file an application for fee review* with the department

---

[2] Act of June 12, 1915, P.L. 736, *as amended*, 77 P.S. §§1-1041.4, 2501-2710.

[3] Our scope of review is limited to determining whether constitutional rights were violated, whether the adjudication is in accordance with the law, and whether the necessary findings of fact are supported by substantial evidence. Section 704 of the Administrative Agency Law, 2 Pa. C.S. §704.

> no more than thirty (30) days following notification of a disputed treatment or ninety (90) days following the original billing date of treatment.

77 P.S. §531(5) (emphasis added).

Once an insurer or employer makes a payment to the extent it deems itself liable, a provider must file her application for fee review within the provided time limit or it will not be considered. *Hospital of the University of Pennsylvania v. Bureau of Workers' Compensation (Tyson Shared Services, Inc.)*, 932 A.2d 1010, 1014 (Pa. Cmwlth. 2007). After a provider has filed an application for fee review with the Bureau of Workers' Compensation (Bureau), an administrative decision shall be made within 30 days. 34 Pa. Code §127.256. A provider or insurer has the right to contest an adverse administrative decision by filing a written request for a hearing with the Bureau. 34 Pa. Code §127.257. A party aggrieved by a fee review adjudication **[*6]** may appeal to this Court. 34 Pa. Code §127.261.

Notably, where the insurer issues an NCP, the insurer may still contest liability for medical care or for a particular treatment on several grounds. If the NCP and the insurer's accompanying liability for medical compensation has not been modified or terminated, the insurer may nonetheless question liability for a particular treatment. 77 P.S. §531(5).

In this case, Employer is responsible for paying Claimant's medical bills for the accepted strain/sprain of the low back and left knee. Employer made payments for treatments related to the work injury, as required by Section 306(f.1)(1)(ii) of the Act, totaling $1,704.59. R.R. at 200a. However, Provider had billed Employer for treatment that Employer asserts is not related to the work injury, totaling $73,188.00. *Id.* at 206a-47a. This resulted in a genuine dispute over the amount due to Provider, implicating the fee review process outlined above. Section 306(f.1) of the Act.[4]

Provider is attempting to resolve a fee dispute, but failed to follow the procedure and timeline provided by the Act. As the Board notes, there is no record evidence of Provider availing herself of the fee review process. R.R. at 44a. The Bureau and its hearing examiners have jurisdiction over fee disputes, not the WCJs. 34 Pa. Code §§127.256, 127.257. If a provider was able **[*7]** to settle a fee dispute through the use of a penalty petition, it would render the fee review provisions of the Act meaningless.[5] Therefore, the Act required Provider to file for fee review prior to filing a penalty petition for nonpayment.

We distinguish our holding in this case from our decision in *Hough v. Workers' Compensation Appeal Board (AC&T Companies)*, 928 A.2d 1173 (Pa. Cmwlth. 2007). Contrary to Provider's assertions, *Hough* does not hold that a provider may file a penalty petition prior to availing itself of the fee review process. Rather, this Court held in *Hough* that Section 306(f.1)(5) of the Act does not require that a *provider* seek fee review before a *claimant* can file a penalty petition for unpaid medical bills. 928 A.2d at 1179. In this case, Provider is the party filing the penalty petition *and* has failed to avail herself of the Act's fee review process. As a result, WCJ DiLorenzo could not properly dispose of the instant fee dispute, and the Board's order will be affirmed.[6],[7]

---

[4] We note that the facts of this case potentially implicate the Act's utilization review (UR) process. However, the Act does not give Provider standing to file for utilization review; only an employer, employee, or insurer may file an initial request for UR. After an adverse UR determination, a provider has standing to appeal to the WCJ. Section 306(f.1)(6)(iv) of the Act, 77 P.S. §531(6).

[5] There is a presumption that the General Assembly does not intend a result that is absurd, impossible of execution or unreasonable when enacting a statute. *Enterprise Rent-A-Car v. Workers' Compensation Appeal Board (Clabaugh)*, 934 A.2d 124, 130 (Pa. Cmwlth. 2007).

[6] We "may affirm on other grounds where grounds for affirmance exist." *Kutnyak v. Department of Corrections*, 748 A.2d 1275, 1279 n.9 (Pa. Cmwlth. 2000); *accord Sloane v. Workers' Compensation Appeal Board (Children's Hospital of Philadelphia)*, 124 A.3d 778, 786 n.8 (Pa. Cmwlth. 2015).

Accordingly, the Board's order is affirmed.

MICHAEL H. WOJCIK, Judge

ORDER

AND NOW, this 6th day of January, 2021, the June 14, 2019 order of the Workers' Compensation Appeal Board in the above-captioned matter is hereby AFFIRMED.

MICHAEL H. WOJCIK, Judge

End of Document

---

[7] Moreover, we would affirm the Board's order even if we were to reach the merits of this appeal. "[L]iability for an injury is distinct from liability for a particular treatment or its cost. The NCP, even if 'open' and binding with respect to liability for the injury, is not dispositive as to the medical care provider's **[*8]** claim for reimbursement for the cost of a particular treatment." *Crozer Chester Medical Center v. Department of Labor & Industry, Bureau of Workers' Compensation, Health Care Services Review Division*, 610 Pa. 459, 22 A.3d 189, 197 (Pa. 2011). Under the Act, an employer is *only* liable for payment of medical bills arising out of work-related injuries. *Mulholland v. Workmen's Compensation Appeal Board (Bechtel Construction)*, 669 A.2d 465, 469 (Pa. Cmwlth. 1995). The moving party bears the burden of proof. 34 Pa. Code §131.121(g). The Board properly held that WCJ DiLorenzo's decision was not supported by substantial and competent evidence. The testimony regarding the coding of unpaid bills of Provider's director of billing and collections, Ms. Angelini, is insufficient to establish a causal relation between the treatment and the work injury. Thus, Provider's failure to introduce any competent testimony in this regard left WCJ DiLorenzo with no basis upon which to grant the penalty petition.

Skay v. Borjeson & Maizel LLC (Workers' Comp. Appeal Bd.)

Commonwealth Court of Pennsylvania

January 28, 2022, Submitted; May 10, 2022, Decided; May 10, 2022, Filed

No. 999 C.D. 2021

Reporter
280 A.3d 19 *; 2022 Pa. Commw. LEXIS 97 **; 2022 WL 2931459

Theresa Skay, Petitioner v. Borjeson & Maizel LLC (Workers' Compensation Appeal Board), Respondent

Subsequent History: [1]** Publication Ordered July 26, 2022.

Prior History: Skay v. Borjeson & Maizel LLC (Workers' Comp. Appeal Bd.), 280 A.3d 342, 2022 Pa. Commw. Unpub. LEXIS 194, 2022 WL 1467829 (Pa. Commw. Ct., May 10, 2022)

Case Summary

Overview
HOLDINGS: [1]-A workers' compensation claimant failed to establish the causal relationship between the prescription medications at issue and her work injury because she only offered prior UR Determinations as proof of that causal relationship, and per 34 Pa. Code § 127.406(b)(1), such determination did not decide the causal relationship between treatments and the work injury; [2]-The claimant failed to prove that the employer violated the Workers' Compensation Act by denying payment due to billing coding issues because she failed to introduce any evidence showing the bills were resubmitted with proper coding.

Outcome
Order affirmed.

LexisNexis® Headnotes

Administrative Law > Judicial Review > Reviewability > Reviewable Agency Action

Workers' Compensation & SSDI > ... > Judicial Review > Standards of Review > Clearly Erroneous Standard of Review

HN1[] **Reviewability, Reviewable Agency Action**

In a workers' compensation appeal, the reviewing court is limited to determining whether necessary findings of fact are supported by substantial evidence, whether an error of law was committed, or whether constitutional rights were violated.

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

HN2[] **Medical Benefits, Authorized Treatment**

Under the Workers' Compensation Act, an

employer is only liable for payment of benefits, both compensation and medical, arising out of work-related injuries. 77 Pa. Stat. Ann. § 411(1). UR Determinations decide only the reasonableness or necessity of the treatment under review, and they do not decide the causal relationship between the treatment under review and the employee's work-related injury. 34 Pa. Code §§ 127.406(a), 127.406(b)(1). The payment of medical expenses and the filing of a UR Determination request also do not establish a causal connection between a medical condition and a claimant's work injury.

Civil Procedure > Appeals > Appellate Briefs

Civil Procedure > Appeals > Reviewability of Lower Court Decisions > Preservation for Review

HN3[] **Appeals, Appellate Briefs**

Failure to develop an issue in a brief will result in waiver.

Workers' Compensation & SSDI > Compensability > Arising Out of Employment > Causation

Workers' Compensation & SSDI > Administrative Proceedings > Awards > Types of Awards

HN4[] **Arising Out of Employment, Causation**

If an employer believes that a claimant's medical expenses are not causally related to the claimant's work injuries, the employer may unilaterally stop paying for those medical expenses. If an employer does so, however, the employer assumes the risk of exposure to possible penalty liability contingent upon a workers' compensation judge's (WCJ's) ruling concerning the causal relation of the medical costs. In determining whether an employer may be liable for penalties for the unilateral cessation of paying for medical benefits, a clear distinction is recognized between reasonableness and causation cases. In all cases where an employer questions the reasonableness and necessity of a claimant's work-related medical bills, the employer can never unilaterally cease medical payments. But, an employer, who questions causation and the subsequent medical bills, may escape penalty provision liability for unilaterally ceasing to pay for these medical bills, if a WCJ later determines that the medical bills were indeed not causally related to the work-related injury. In the latter scenario, the employer is not subject to penalties under the Workers' Compensation Act.

Workers' Compensation & SSDI > Compensability > Arising Out of Employment > Causation

HN5[] **Arising Out of Employment, Causation**

UR Determinations do not decide the causal relationship between treatments and the work injury. 34 Pa. Code § 127.406(b)(1).

Civil Procedure > Appeals > Appellate Briefs

Civil Procedure > Appeals > Reviewability of Lower Court Decisions > Preservation for Review

HN6[] **Appeals, Appellate Briefs**

The reviewing court's function is not to develop the parties' arguments. Appellate courts are neither obliged, nor even particularly equipped, to develop an argument for a party.

Judges: BEFORE: HONORABLE RENÉE COHN JUBELIRER, President Judge, HONORABLE ELLEN CEISLER, Judge, HONORABLE STACY WALLACE, Judge. OPINION BY JUDGE WALLACE.

Opinion by: STACY WALLACE

Opinion

[*20] OPINION BY JUDGE WALLACE

Theresa Skay (Claimant) petitions for review of the Workers' Compensation Appeal Board's (Board) August 16, 2021 Order that affirmed a Workers' Compensation Judge's (WCJ) October 27, 2020 Decision denying Claimant's Penalty Petition. On appeal, Claimant argues the Board erred as a matter of law, as Borjeson & Maizel LLC (Employer) unilaterally refused to pay for some of Claimant's prescription medications that had been previously found to be reasonable and necessary in an unchallenged Utilization Review (UR) Determination. Upon review, we affirm.

I. Background

On December 18, 2009, Claimant fell in a crosswalk while in the course of her employment. Reproduced Record (R.R.) at 18a. By May 21, 2013, Claimant's work injury had been established as "status post L5-S1 fusion, bilateral SI joint disease with SI joint mediated pain," and "reflex sympathetic dystrophy of the lower left extremity." *Id.* A WCJ denied Claimant's Review Petition, which sought to add mood disorder and major **[**2]** depressive episodes to the work injury, on July 30, 2019. *Id.* That WCJ also found that Claimant "does not suffer from postural orthostatic tachycardia syndrome [POTS]." *Id.*

During Claimant's receipt of workers' compensation benefits, UR Determinations were completed on August 17, 2015, and December 11, 2017. *Id.* Both UR Determinations found that every medication prescribed to Claimant by Emique Aradillas-Lopez, M.D. was reasonable and necessary. *Id.*

[*21] On November 12, 2019, Claimant filed a Penalty Petition, alleging that Employer violated the Workers' Compensation Act (Act)[1] by failing to pay for some of Claimant's prescription medications. R.R. at 19a. Many of the medications for which Employer ceased payment had been approved as reasonable and necessary as part of the 2015 and 2017 UR Determinations. R.R. at 230a-31a, 245a.

After conducting hearings and reviewing the evidence in this matter, the WCJ found that "the unpaid bills . . . were due to a lack of causal relationship or a billing code issue. Claimant failed to present any medical evidence to establish that the denied medications were related to the work injury or the bills were ever re-submitted with the proper coding." **[**3]** R.R. at 22a. The WCJ accepted the opinions of Employer's experts, found that the medications at issue were not related to the work injury, and denied Claimant's Penalty Petition. R.R. at 20a-22a.

Claimant appealed to the Board, asserting that the WCJ erred as a matter of law, because the UR Determinations, which were not appealed,

---

[1] Act of June 2, 1915, P.L. 736, *as amended*, 77 P.S. §§ 1-1041.4, 2501-2710.

showed that the prescription drugs at issue were being utilized to treat Claimant's work injuries. R.R. at 26a-27a. The Board pointed out that UR Determinations only decide the reasonableness or necessity of treatments and not the causal relationship to the work injury. R.R. at 41a. As a result, the Board opined that Claimant could not rely on the prior UR Determinations to establish a causal relationship to the work injury. R.R. at 42a. Since Claimant failed to present any other evidence to establish a causal relationship to the work injury, the Board found that Claimant failed to meet her burden of proving the prescription drugs at issue were related to the work injury. *Id.* Accordingly, the Board affirmed the WCJ's denial of Claimant's Penalty Petition. R.R. at 43a.

II. Discussion

On appeal, Claimant again argues that the WCJ "erred as a matter of law by denying **[**4]** the Penalty Petition because the Employer unilaterally refused to pay for medical treatment that had been subjected to an unchallenged [UR] Determination that found the treatment reasonable and necessary." Petitioner's Br. at 12. Claimant does not present any other challenges to Employer's evidence that the prescription medications at issue in this matter were unrelated to the work injury. *See id.* at 18-22. Instead, Claimant relies solely on the prior, unchallenged UR Determinations, which Claimant believes established that the prescription medications at issue in this matter "were determined to be reasonable and necessary for treatment of Claimant's work injuries." *Id.* at 18.

HN1[↑] In a workers' compensation appeal, we are "limited to determining whether necessary findings of fact are supported by substantial evidence, whether an error of law was committed, or whether constitutional rights were violated." *Elberson v. Workers' Comp. Appeal Bd. (Elwyn, Inc.)*, 936 A.2d 1195, 1198 n.2 (Pa. Cmwlth. 2007).

HN2[↑] "Under the Act, . . . an employer is *only* liable for payment of benefits, both compensation and medical, arising out of work-related injuries." *Mulholland v. Workmen's Comp. Appeal Bd. (Bechtel Constr.)*, 669 A.2d 465, 467 (Pa. Cmwlth. 1995) (citing Section 301(c)(1) of the Act, 77 P.S. § 411(1)) (emphasis in original); *see also* Section 301(a) of the Act, 77 P.S. §431. UR Determinations "decide only the reasonableness or necessity of the **[**5]** **[*22]** treatment under review," and they do not decide "[t]he causal relationship between the treatment under review and the employe's work-related injury." 34 Pa. Code §§127.406(a), 127.406(b)(1). The payment of medical expenses[2] and the filing of a UR Determination request also do not "establish a causal connection between a medical condition and a claimant's work injury." *Securitas Sec. Servs. USA, Inc. v. Workers' Comp. Appeal Bd. (Schuh)*, 16 A.3d 1221, 1224 (Pa. Cmwlth. 2011).

HN4[↑] If an employer believes that a claimant's medical expenses are not causally related to the claimant's work injuries, the employer may unilaterally stop paying for those medical expenses. *Listino v. Workmen's Comp. Appeal Bd. (INA Life Ins. Co.)*, 659 A.2d 45, 48

---

[2] Although Claimant noted before the Board that Employer was paying for some of the medications after the December 2017 UR Determination, Claimant did not argue that Employer's prior payments for the prescriptions at issue established their connection to the work injury. Claimant also did not raise or brief this issue on appeal. Therefore, the issue is waived. *See* Pa.R.A.P. 2116-2119; *Pa. Gaming Control Bd. v. Unemployment Comp. Bd. of Rev.*, 47 A.3d 1262, 1265 n.5 (Pa. Cmwlth. 2012) (concluding that ***HN3***[↑] failure to develop an issue in a brief will result in waiver).

(Pa. Cmwlth. 1995). If an employer does so, however, the employer "assumes the risk of exposure to possible penalty liability contingent upon a [WCJ]'s ruling concerning the causal relation of the medical costs." *Id.*

> In determining whether an employer may be liable for penalties for the unilateral cessation of paying for medical benefits, this Court has recognized a "clear distinction . . . between 'reasonableness' and 'causation' cases." *Listino*, 659 A.2d at 47. "In all cases where an employer questions the reasonableness and necessity of a claimant's work-related medical bills," the "employer can never unilaterally cease medical payments." *Id.* at 47, n.6. But, an "employer, who questions 'causation' and the subsequent medical **[**6]** bills, may escape penalty provision liability for unilaterally ceasing to pay for these medical bills, if a [WCJ] later determines that the medical bills [were] indeed not causally related to the work-related injury." *Id.* at 47 (emphasis in the original). In the latter scenario, "the employer is . . . not subject to penalties under the Act." *Id.*

W&W Contractors, Inc. v. Workers' Comp. Appeal Bd. (Holmes) (No. 336 C.D. 2020, filed June 28, 2021), 258 A.3d 1164 (Pa. Cmwlth. 2021) (Table).

Employer unilaterally refused to pay for some of Claimant's prescription medications, because Employer believed that those prescription medications were not causally related to Claimant's work injury. Employer was legally permitted to do this, but Employer would have been liable for penalties if a WCJ determined that the prescription medications at issue were causally related to Claimant's work injury. *See Listino*, 659 A.2d 48; *W&W Contractors*, 258 A.3d 1164.

The only evidence Claimant presented or referenced to establish a causal relationship between the prescription drugs at issue and the work injury was the prior UR Determinations. ***HN5***[↑] As outlined above, UR Determinations do not decide the causal relationship between treatments and the work injury. 34 Pa. Code §127.406(b)(1). Thus, Claimant did not present any evidence establishing that the prescription medications were causally related to the work injury. Accordingly, **[**7]** the WCJ's findings and the Board's conclusions, that Claimant failed to establish that the prescription medications at issue in this matter were causally related to Claimant's work injury, are free of legal error.

[*23] In addition to challenging the Board's conclusion that the medications at issue in this matter were not causally related to Claimant's work injury, Claimant briefly argued that Employer's denial of payment for some of the medications due to billing coding issues was improper. Claimant asserts that the billing coding issues are "no legitimate defense," and that the "carrier can change these codes at a whim" and "cannot escape liability based on its own internal policy." Petitioner's Br. at 21. Claimant did not provide any citations to authority for these assertions. ***HN6***[↑] This Court's function is not to develop the parties' arguments, and we will not do so for Claimant. *See Commonwealth v. Brown*, 649 Pa. 293, 196 A.3d 130, 185 n.21 (Pa. 2018) (stating that appellate courts are "neither obliged, nor even particularly equipped, to develop an argument for a party. To do so places the Court in the conflicting roles of advocate and neutral arbiter.") (citation omitted).

Additionally, we note that the WCJ did not find that Employer's denial of payment for **[**8]** medications due to billing coding issues was

proper. Instead, the WCJ found that Claimant failed to carry her burden of proof with regard to establishing that Employer violated the Act by denying payment due to billing coding issues. R.R. at 22a (finding that "bills were denied based on billing code issues and asked to be re-submitted," that one bill "was denied by the bill re-pricing company as 'this code is either deleted, non-covered, bundled, invalid or the status indicator is not allowable under the provider's jurisdiction,' [and] [t]he [C]laimant's counsel failed to present any evidence that the bill was resubmitted with the proper coding," and that "[C]laimant failed to present any . . . evidence to establish that . . . the bills were ever re-submitted with the proper coding") (citation omitted). The Board similarly concluded that Claimant "failed to present evidence that the bills . . . were resubmitted with the proper . . . coding." R.R. at 42a.

Having reviewed the record, we agree that Claimant did not present any evidence to establish that the bills were resubmitted with the proper coding. Thus, we conclude that the WCJ's finding and the Board's conclusion, that Claimant **[**9]** failed to prove that Employer violated the Act, are free of legal errors. As a result, Employer is absolved of penalty liability.

III. Conclusion

UR determinations cannot be used to establish the causal relationship between a treatment and a work injury. Claimant failed to establish the causal relationship between the prescription medications at issue in this matter and her work injury, because Claimant only offered prior UR Determinations as proof of that causal relationship. Additionally, Claimant failed to prove that Employer violated the Act by denying payment due to billing coding issues, because Claimant failed to introduce any evidence showing the bills were resubmitted with proper coding. Accordingly, we affirm the Board's order affirming the WCJ's decision to deny Claimant's Penalty Petition.

STACY WALLACE, Judge

ORDER

AND NOW, this 10th day of May 2022, the Order of the Workers' Compensation Appeal Board, dated August 16, 2021, is **AFFIRMED**.

STACY WALLACE, Judge

End of Document

UPMC Ben. Mgmt. Servs. v. United Pharm. Servs. (Bureau of Workers' Comp. Fee Rev. Hearing Off.)

Commonwealth Court of Pennsylvania

June 22, 2022, Argued; December 15, 2022, Decided; December 15, 2022, Filed

No. 558 C.D. 2021

Reporter
287 A.3d 474 *; 2022 Pa. Commw. LEXIS 155 **; 2022 WL 17684990

UPMC Benefit Management Services, Inc. d/b/a UPMC Work Partners, Petitioner v. United Pharmacy Services (Bureau of Workers' Compensation Fee Review Hearing Office), Respondent

Case Summary

Overview
HOLDINGS: [1]-None of the three prerequisites for deeming a fee review application premature had been met where the medical provider issued a medical-only notice of compensation payable accepting liability for claimant's work-related injury; [2]-The provider merely denied payment on the basis that the prescribed compound cream was not casually related to the claimant's work injury.

Outcome
Judgment affirmed.

LexisNexis® Headnotes

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

HN1[] **Medical Benefits, Authorized Treatment**

Pursuant to WC Regulation 127.255, the Bureau of Workers' Compensation will return applications for fee review prematurely filed by providers when one of the following exists: (1) The insurer denies liability for the alleged work injury.(2) The insurer has filed a request for utilization review of the treatment under Subchapter C (relating to medical treatment review). (3) The 30-day period allowed for payment has not yet elapsed, 34 Pa. Code § 127.255.

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

HN2[] **Medical Benefits, Authorized Treatment**

An employer is obligated to pay for reasonable medical expenses that are causally related to the work injury. Under Section 306(f.1)(5) of the Act, 77 Pa. Stat. Ann. § 531(5), the employer must pay the claimant's medical bills within 30 days of receiving them, unless the employer disputes the reasonableness and necessity of the treatment. If the employer believes that the treatment is not reasonable and necessary, it must submit the bills for a

utilization review or face the possibility of a penalty. In addition, if the employer refuses to pay bills because it believes they are not causally related to the work injury, the employer runs the risk of being assessed a penalty if the workers' compensation judge determines that they are, in fact, causally related.

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

HN3[] **Medical Benefits, Authorized Treatment**

Accepting liability for a work-related injury by means of an notice-of-compensation does not preclude an insurer's ability to question liability for a particular treatment, 77 Pa. Stat. Ann. § 531(5). Either an employer or its insurer may file a petition for medical review of treatment contesting the causal relatedness of the prescribed treatment to the underlying work injury. In the alternative, either an employer or its insurer may petition for utilization review of the reasonableness or necessity of a prescribed treatment, § 531(6).

Workers' Compensation & SSDI > Administrative Proceedings > Costs & Attorney Fees

HN4[] **Administrative Proceedings, Costs & Attorney Fees**

An employer who unilaterally ceases payment of a claimant's medical bills based solely on causation assumes the risk that it will be subject to penalties, contingent upon a workers' compensation judge's ruling concerning the causal relation of the medical costs.

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

HN5[] **Medical Benefits, Authorized Treatment**

Further, a claimant does not bear an ongoing obligation to establish the causal connection between each subsequently prescribed treatment and the accepted work injury after an employer's liability for the work injury is established.

Insurance Law > Types of Insurance > Malpractice & Professional Liability Insurance > Healthcare Providers

HN6[] **Malpractice & Professional Liability Insurance, Healthcare Providers**

Fee review is a process for medical care providers to dispute the amount or timeliness of an insurer's payment for a particular treatment, which are relatively simple matters, 77 Pa. Stat. Ann. § 531(5).

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

HN7[] **Medical Benefits, Authorized Treatment**

Indeed, Section 306(f.1)(5) of the Workers' Compensation Act, which the regulation addresses, indicates that it is sufficient if the insurer denies liability for a particular treatment, 77 Pa. Stat. Ann. § 531(5).

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

HN8[] **Medical Benefits, Authorized Treatment**

Section 306(f.1)(5) specifically provides that an insurer's dispute regarding a particular treatment may suspend the 30-day payment period. Section 306(f.1)(5) of the Workers' Compensation Act, 77 Pa. Stat. Ann. § 531(5). Critically, this portion of Section 306(f.1)(5) does not pertain to instances where the employer has denied liability for the injury. It governs challenges raised through the utilization review process, which can only arise after the employer has accepted liability for the underlying injury.

Judges: **[**1]** BEFORE: HONORABLE RENÉE COHN JUBELIRER, President Judge, HONORABLE PATRICIA A. McCULLOUGH, Judge, HONORABLE CHRISTINE FIZZANO CANNON, Judge, HONORABLE ELLEN CEISLER, Judge, HONORABLE LORI A. DUMAS, Judge. DISSENTING OPINION BY PRESIDENT JUDGE COHN JUBELIRER.

Opinion by: CHRISTINE FIZZANO CANNON

Opinion

[*475] OPINION BY JUDGE FIZZANO CANNON

UPMC Benefit Management Services, d/b/a UPMC Work Partners (UPMC), petitions for review of the April 23, 2021 decision of the Bureau of Workers' Compensation (Bureau) Medical Fee Review **[*476]** Hearing Office (Hearing Office). The Hearing Office reversed the dismissal by the Health Care Services Review Division of the Bureau's Fee Review Section (Fee Review Section) of three fee review applications submitted by United Pharmacy Services (Pharmacy), as prematurely filed. Upon review, we affirm the Hearing Office's decision.

I. Background

In October 2019, Lisa Cass (Claimant) sustained a work-related injury while in the employ of Pinnacle Health Medical Services (Employer). Hearing Off. Decision, 4/23/21 at 1, Finding of Fact (F.F.) 1, Reproduced Record (R.R.) at 52a. Claimant's injury was accepted by a medical-only notice of compensation payable (NCP) as "lower back area sprain/low back **[**2]** sprain from picking up a laptop bag." *Id.* In January 2020, Claimant was prescribed compound cream with instructions to apply one to three pumps to the affected area two to four times daily, as needed. F.F. 3. Between January and April 2020, Pharmacy issued three separate bills, each requesting payment of $2,249.98 for the compound cream dispensed to Claimant. F.F. 4-6. UPMC denied payment on the basis that the prescribed treatment was "not work related." F.F. 4-6.

Between March and June 2020, Pharmacy filed three applications for fee review pursuant to Section 306(f.1) of the Workers' Compensation Act (Act),[1] 77 P.S. § 531, disputing UPMC's failure to pay the bills. F.F. 1 & 7; *see also* Fee Review Applications, R.R. at 4a-5a, 13a-14a & 24a-25a. The Fee Review Section denied each of Pharmacy's fee review applications as

[1] Act of June 2, 1915, P.L. 736, *as amended*, 77 P.S. §§ 1-1041.4, 2501-2710.

prematurely filed on the basis that the issue of the "causal relatedness" of the prescribed compound cream to the work injury remained outstanding. F.F. 8. Pharmacy requested a hearing to contest the three fee review determinations, asserting that the applications were not premature because Claimant's injury was accepted by Employer, no party petitioned for utilization review, and UPMC's 30-day period in which to remit payment following **[**3]** receipt of the disputed bills had lapsed. F.F. 9-10 & 13.

By decision circulated April 23, 2021, the Hearing Office reversed the determinations of the Fee Review Section and ordered UPMC to issue payment plus statutory interest to Pharmacy for the medications dispensed to Claimant. Hearing Off. Decision, 4/23/21 at 1 & 6-7, R.R. at 50a & 55a-56a. The Hearing Office reasoned that UPMC's denial of payment on the basis of lack of "causal relatedness" did not render Pharmacy's fee review application premature, because this "defense" in fact constituted a challenge to the reasonableness and necessity of Claimant's treatment, which UPMC should have disputed through the utilization review process. *See* Hearing Off. Decision, 4/23/21 at 6, R.R. at 55a (first citing *Workers' First Pharmacy Servs., LLC v. Bureau of Workers' Comp. Fee Rev. Hearing Off. (Gallagher Bassett Servs.)*, 225 A.3d 613 (Pa. Cmwlth. 2020); and then citing *Omni Pharmacy Servs., LLC v. Bureau of Workers' Comp. Fee Rev. Hearing Off.*, 241 A.3d 1273, 1274 (Pa. Cmwlth. 2020), *reargument denied* (Dec. 18, 2020), *appeal denied sub nom. Omni Pharmacy Servs., LLC v. Bureau of Workers' Comp. Fee Rev. Hearing Off. (Am. Interstate Ins. Co.)*, 257 A.3d 1212 (Pa. 2021)). Further, the Hearing Office concluded that *Crozer Chester Medical Center v. Department of Labor and Industry, Bureau of Workers' Compensation Health Care Services Review* ***[*477]*** *Division*, 610 Pa. 459, 22 A.3d 189 (Pa. 2011) (*Crozer Chester II*), was inapposite, as that case turned on whether the provider had alleged sufficient facts in support of its request for *mandamus* relief to compel issuance of a fee review determination. Hearing Off. Decision, 4/23/21 at 6, R.R. at 55a. The Hearing Office, therefore, determined that **[**4]** Pharmacy did not file the three fee review applications prematurely. *See id.* at 6, R.R. at 55a (citing Workers' Compensation (WC) Regul. 127.255, 34 Pa. Code § 127.255). The Hearing Office concluded that UPMC failed to meet its burden of proving by a preponderance of the evidence that it properly reimbursed Pharmacy. *Id.* (citing WC Regul. 127.255(f); 34 Pa. Code § 127.259(f)).

UPMC petitioned this Court for review.[2]

II. Issues

Before this Court,[3] UPMC argues that the Hearing Office erred in applying *Workers' First* and *Omni* to determine that Pharmacy's fee review applications were not prematurely filed where the dispute "turn[ed] solely on . . . liability for a particular medical treatment." UPMC's Br. at 21. UPMC contends that even where a claimant's injury is accepted by means

---

[2] Simultaneously with the filing of its petition for review, UPMC filed an application for supersedeas, which this Court ultimately denied by order dated August 5, 2021. *See* Cmwlth. Ct. Order, 8/5/21.

[3] Our review in medical fee review cases determines whether constitutional rights were violated, whether an error of law was committed, or whether the necessary findings of fact were supported by substantial evidence. *Workers' First Pharmacy Servs., LLC v. Bureau of Workers' Comp. Fee Rev. Hearing Off. (Gallagher Bassett Servs.)*, 225 A.3d 613, 616 n.3 (Pa. Cmwlth. 2020). Regarding questions of law, our scope of review is plenary and our standard of review is *de novo*. *Id.*

of an open NCP, "the insurer may nonetheless question liability for a particular treatment." *Id.* at 21 (quoting *Crozer Chester II*, 22 A.3d at 195); *see also Crozer Chester II*, 22 A.3d at 197 (explaining that "liability for an injury is distinct from liability for a particular treatment or its cost. The NCP, even if 'open' and binding with respect to liability for the injury, is not dispositive as to the medical care provider's claim for reimbursement for the cost of a particular treatment."). Further, UPMC asserts that utilization review may not decide the causal relationship between **[**5]** the treatment under review and the employee's work-related injury. *See id.* at 14 (citing WC Regul. 127.406(b)(1), 34 Pa. Code § 127.406(b)(1)).[4] UPMC maintains that "[i]n cases in which liability for a particular treatment is at issue, the claimant, not the medical provider, must pursue compensation before a workers' compensation judge in the regular course." *Id.* at 17 (quoting *Crozer Chester II*, 22 A.3d at 195 (first citing Section 306(f.1) of the Act, 77 P.S. § 531(6)(iv) (utilization review); and then Section 401.1 of the Act, added by the Act of February 8, 1972, P.L. 25, 77 P.S. § 710 (liability for compensation generally))). UPMC contends that our Supreme Court's decision in "*Crozer Chester* [*II*] **[*478]** supersedes this Court's analyses in both *Workers' First* [] and *Omni* pursuant to the doctrine of *stare decisis*." *Id.* at 19 (citing *Rodriguez v. Workers' Comp. Appeal Bd. (Adecco Grp. N. Am.)* (Pa. Cmwlth., No. 869 C.D. 2019, filed Jan. 6, 2021), 247 A.3d 1180). UPMC requests that this Court reverse the Hearing Office's April 23, 2021 decision and dismiss Pharmacy's three fee review applications. *Id.* at 2 & 23.

Pharmacy counters that an employer or insurer **[**6]** must use the utilization review process to dispute liability for treatment on the basis that it is unrelated to the work injury, because such a challenge constitutes a dispute regarding the reasonableness and necessity of that treatment. Pharmacy's Br. at 8-9 (first citing *Workers' First*; and then citing *Omni*). Pharmacy contends that this Court's clarification of the law in *Workers' First* and *Omni* has the beneficial effect of preventing an employer or insurer from defeating a fee review petition merely by asserting that billed treatment or service was not causally related to the work injury. *Id.* at 12. Further, Pharmacy asserts that deeming its fee review applications premature on the basis of UPMC's asserted "defense" of lack of "causal relation" denies Pharmacy due process by depriving it and other providers of recourse for nonpayment. *Id.* at 15 & 18-19. Pharmacy echoes the Hearing Office in distinguishing *Crozer Chester II* as involving the narrow question of whether a hospital alleged sufficient facts to support its petition for review in *mandamus* seeking to compel the Pennsylvania Department of Labor and Industry (Department) to reach the merits of its fee review application. ***[**7]*** *Id.* at 20 (citing *Crozer Chester II*, 22 A.3d at 191).

After the parties presented their arguments during this Court's October 2021 *en banc* session, we ordered supplemental briefing to address the potential impact of the Pennsylvania Supreme Court's recent decision

---

[4] WC Regulation 127.406(b)(1) states that "[utilization review organizations] may not decide . . . [t]he causal relationship between the treatment under review and the employe's work-related injury." 34 Pa. Code § 127.406(b)(1). Similarly, WC Regulation 127.470(b) provides that

> [utilization review r]eviewers shall assume the existence of a causal relationship between the treatment under review and the employe's work-related injury. Reviewers may not consider or decide issues such as whether the employe is still disabled, whether maximum medical improvement has been obtained, quality of care or the reasonableness of fees.

34 Pa. Code § 127.470(b).

in *Keystone Rx LLC v. Bureau of Workers' Compensation Fee Review Hearing Off. (Compservices Inc./AmeriHealth Casualty Services)*, 265 A.3d 322 (Pa. 2021), on their respective positions. *See* Cmwlth. Ct. Order, 12/27/21. Specifically, this Court instructed the parties to address whether a fee review petition may be dismissed as premature based on a causal relationship challenge where (1) the work injury is accepted, (2) no utilization review petition has been filed, and (3) payment has not been made within the statutory period. *Id.*; *see also* 34 Pa. Code § 127.255.

The parties submitted supplemental briefs and argued their positions before this Court's June 2022 *en banc* panel. UPMC contended that deeming Pharmacy's fee review applications premature on the basis of a "causal relatedness" denial would not infringe upon Pharmacy's due process rights because, under *Keystone Rx*, a non-treating provider does not have a constitutionally protected interest in goods or services where it is not entitled to payment under the Act. UPMC's Suppl. Br. at 13 & 16. Pharmacy countered that the Pennsylvania Supreme Court's holding in *Keystone Rx* that non-treating providers **[**8]** were not entitled to notice and an opportunity to intervene in utilization review proceedings does not bear upon whether Pharmacy prematurely filed the disputed fee review applications. *See* Pharmacy's Suppl. Br. at 4-5. Further, Pharmacy noted that, unlike the insurer in *Keystone Rx*, UPMC did not request a utilization review here. *Id.*

We agree with Pharmacy that *Keystone Rx* does not preclude affirmance of the Hearing Office's April 23, 2021 decision. That Pharmacy would be unable to intervene in any utilization review proceedings **[*479]** initiated by UPMC does not alter the preclusive effect those proceedings would have had on Pharmacy's fee review applications.

III. Discussion

Section 306(f.1) of the Act provides, in relevant part:

> (5) The employer or insurer shall make payment and providers shall submit bills and records in accordance with the provisions of this section. All payments to providers for treatment provided pursuant to this [A]ct shall be made within thirty (30) days of receipt of such bills and records unless the employer or insurer disputes the reasonableness or necessity of the treatment provided pursuant to paragraph (6). The nonpayment to providers within thirty (30) days for treatment for which a bill and records have been **[**9]** submitted shall only apply to that particular treatment or portion thereof in dispute; payment must be made timely for any treatment or portion thereof not in dispute. A provider who has submitted the reports and bills required by this section and who disputes the amount or timeliness of the payment from the employer or insurer shall file an application for fee review with the [D]epartment no more than thirty (30) days following notification of a disputed treatment or ninety (90) days following the original billing date of treatment. If the insurer disputes the reasonableness and necessity of the treatment pursuant to paragraph (6) [delineating the utilization review process], the period for filing an application for fee review shall be tolled as long as the insurer has the right to suspend payment to the provider pursuant to the provisions of this

> paragraph. Within thirty (30) days of the filing of such an application, the [D]epartment shall render an administrative decision.
>
> (6) Except in those cases in which a workers' compensation judge asks for an opinion from peer review under [S]ection 420 [of the Act, 77 P.S. §§ 831, 832], disputes as to reasonableness or necessity of treatment by a health care provider shall be resolved **[**10]** in accordance with the following provisions:
>
> > (i) The reasonableness or necessity of all treatment provided by a health care provider under this act may be subject to prospective, concurrent or retrospective utilization review at the request of an employe, employer or insurer. The [D]epartment shall authorize utilization review organizations to perform utilization review under this [A]ct. Utilization review of all treatment rendered by a health care provider shall be performed by a provider licensed in the same profession and having the same or similar specialty as that of the provider of the treatment under review.

77 P.S. § 531(5), (6)(i).

HN1[] Pursuant to WC Regulation 127.255, "[t]he Bureau [of Workers' Compensation] will return applications for fee review prematurely filed by providers when one of the following exists":

> (1) The insurer denies liability for the alleged work injury.
>
> (2) The insurer has filed a request for utilization review of the treatment under Subchapter C (relating to medical treatment review).
>
> (3) The 30-day period allowed for payment has not yet elapsed . . . .

34 Pa. Code § 127.255.

In *Workers' First*, this Court reasoned:

> Had [the e]mployer sought utilization review, its 30-day deadline to pay [the p]harmacy's invoice **[**11]** would have been stayed. [A c]laimant may be under treatment **[*480]** for an array of medical problems, only some of which relate to the work injury. It is for the [u]tilization [r]eview [o]rganization to sort this out. If the compound cream was prescribed for a non-work-related injury of [c]laimant, *a fortiori* it is not reasonable or necessary for treatment of her accepted work injury. [The e]mployer's stated reason for denying [the p]harmacy's invoice was that the "diagnosis is inconsistent with the procedure." . . . *This is just another way of stating that the compound cream was not a reasonable or necessary "procedure" for treating* [the c]*laimant's "diagnosis," i.e., a shoulder sprain*.
>
> An application for fee review is deemed premature in three circumstances: (1) where the insurer denies liability for the alleged work injury; (2) where the insurer has filed a request for utilization review; or (3) where the 30-day period insurer is allowed for payment of a provider's invoice has not yet elapsed. 34 Pa. Code § 127.255. Here, the Hearing Office concluded that [the p]harmacy's fee review was premature because [*the e*]*mployer denied that the compound cream was related to* [*the c*]*laimant's accepted work injury*. The Hearing **[**12]** Office erred because [the e]mployer's non[]payment did not fit any of the exceptions to the rule that an employer must pay an invoice within 30 days. *See* 34 Pa. Code § 127.255. [The e]mployer did not

> file a modification petition to revise [the c]laimant's accepted work injury and did not seek utilization review. [The e]mployer expressly accepted liability for [the c]laimant's work injury in the nature of a right shoulder strain both in the [notice of temporary compensation payable] and in the [compromise and release a]greement.
>
> [The e]mployer contends that the compound cream was not related to the accepted work injury, *i.e.*, a shoulder sprain. It argues that its liability for this treatment must be established in a claim petition proceeding. We disagree. The work injury has been accepted, and the sole question is whether the compound cream was reasonable and necessary for treatment of the accepted work injury. *This is an issue for utilization review.*
>
> We hold that [*the e*]*mployer was obligated to seek utilization review* upon receipt of [the p]harmacy's invoice.

Workers' First, 225 A.3d at 620-21 (emphasis added) (footnotes omitted).

HN2[] Similarly, this Court has explained:

> An employer is obligated to pay for reasonable medical expenses that are causally **[**13]** related to the work injury. *Listino v. Workmen's Comp*[.] *Appeal* [*Bd*.] *(INA Life Ins*[.] *Co*[.]), 659 A.2d 45, 47 (Pa. Cmwlth. 1995). Under Section 306(f.1)(5) of the Act, 77 P.S. § 531(5), the employer must pay the claimant's medical bills within 30 days of receiving them, unless the employer disputes the reasonableness and necessity of the treatment. If the employer believes that the treatment is not reasonable and necessary, it must submit the bills for a utilization review or face the possibility of a penalty. *Hough v. Workers' Comp*[.] *Appeal* [*Bd*.] *(AC & T* [*Cos*.]), 928 A.2d 1173, 1180 (Pa. Cmwlth. 2007). In addition, if the employer refuses to pay bills because it believes they are not causally related to the work injury, the employer runs the risk of being assessed a penalty if the [workers' compensation judge] determines that they are, in fact, causally related. *Listino*, 659 A.2d at 48.

CVA, Inc. v. Workers' Comp. Appeal Bd. (Riley), 29 A.3d 1224, 1227 (Pa. Cmwlth. 2011) (footnote omitted).

Likewise, in *Omni*, we held that in denying payment to a pharmacy for treatment on the basis of the "issue of causation" **[*481]** between the claimant's work injury and the prescribed compound cream, the "[e]mployer [was] challenging whether the compound cream prescribed to [the c]laimant constituted reasonable and necessary treatment for the accepted work injury," a question reserved for the utilization review process. *Omni*, 241 A.3d at 1275 & 1278 (citing *Workers' First*, 225 A.3d at 621).[5]

None of the three prerequisites for deeming a fee review application premature has been met here. *See id.* UPMC issued a medical-only NCP accepting liability for Claimant's work-related injury. *See* F.F. 1. UPMC thereafter denied payment for the cost of the prescribed

---

[5] We clarify that *Workers' First* and *Omni* do not stand for the proposition that liability for a claimant's prescribed treatment may only be disputed through the utilization review process. Rather, the import of *Workers' First* and *Omni* is that *where an employer or insurer also seeks to render a provider's fee review application* ***[**14]*** *premature*, a dispute regarding the causal connection between the prescribed treatment and the underlying work injury must be reframed as a challenge to the reasonableness and necessity of the treatment through the utilization review process. *See Omni*, 241 A.3d at 1275 & 1278 (citing *Workers' First*, 225 A.3d at 621) (additional citations omitted).

compound cream on the basis that the treatment was not causally related to Claimant's work injury. *See* F.F. 4-6; Hearing Off. Decision, 4/23/21 at 3 n.3, R.R. at 52a. ***HN3***[⬆] As noted by UPMC, accepting liability for a work-related injury by means of an NCP does not preclude an insurer's ability to question liability for a particular treatment. *See Crozer Chester II*, 22 A.3d at 195 (citing Section 306(f.1)(5) of the Act, 77 P.S. § 531(5)). Either an employer or its insurer may file a petition for medical review of treatment contesting the causal relatedness of the prescribed treatment to the underlying work injury. *See CVA, Inc.*, 29 A.3d at 1229; *see also Ralph Martin Constr. v. Castaneda-Escobar (Workers' Comp. Appeal Bd.)* (Pa. Cmwlth., No. 341 C.D. 2021, filed Aug. 1, 2022), slip op. at 1 & 3, 280 A.3d 1089. In the alternative, either an employer or its insurer may petition for utilization review of the reasonableness or necessity of a prescribed treatment. *See* Section 306(f.1)(6) of the Act, 77 P.S. § 531(6).

However, neither Employer nor UPMC pursued either means of recourse in the instant matter. UPMC merely denied payment on the basis that the prescribed compound cream was not causally related to Claimant's work injury. **[**15]** *See* F.F. 4-6. This inaction does not satisfy any of the three specific prerequisites for rendering a fee review application premature under WC Regulation 127.255, 34 Pa. Code § 127.255. ***HN4***[⬆] "An employer who unilaterally ceases payment of a claimant's medical bills based solely on causation assumes the risk that it will be subject to penalties, contingent upon a [workers' compensation judge's] ruling concerning the causal relation of the medical costs." *Roadway Exp., Inc. v. Workers' Comp. Appeal Bd. (Iwasko)*, 723 A.2d 1076, 1079 (Pa. Cmwlth. 1999). Accordingly, we conclude that UPMC was obligated to dispute liability for Claimant's treatment through the utilization review process in order to render Pharmacy's fee review applications premature. UPMC's "defense" that the treatment was not causally related to Claimant's work injury was "just another way of stating that the compound cream was not a reasonable or necessary 'procedure' for treating Claimant's 'diagnosis[.]'" *Workers' First*, 225 A.3d at 620-21; *see also Omni*, 241 A.3d at 1275 & 1278.

Relying on *Crozer Chester II*, UPMC maintains that "[i]n cases in which liability for a particular treatment is at issue, the **[*482]** claimant, not the medical provider, must pursue compensation before a workers' compensation judge in the regular course." UPMC's Br. at 17 (quoting *Crozer Chester II*, 22 A.3d at 195 (citing Section 306(f.1)(6)(iv) of the Act, 77 P.S. § 531(6)(iv) (utilization review); Section 401.1 of the Act, 77 P.S. § 710 (liability for compensation **[**16]** generally)). Thus, according to UPMC, Claimant bore the burden of establishing UPMC's liability for the prescribed treatment before a workers' compensation judge following UPMC's issuance of its "causal relatedness" denial.

However, *Crozer Chester II* is inapposite. The portion of *Crozer Chester II* cited by UPMC merely explains that providers may not be parties to a utilization review dispute between the claimant and employer and, in practice, the claimant brings the utilization review petition on the provider's behalf. *See Crozer Chester II*, 22 A.3d at 195 (citing Section 306(f.1)(6)(iv) of the Act, 77 P.S. § 531(6)(iv)). ***HN5***[⬆] Further, a claimant does not bear an ongoing obligation to establish the causal connection between each subsequently prescribed treatment and the accepted work injury after an

employer's liability for the work injury is established. *See Gens v. Workmen's Comp. Appeal Bd. (Rehab. Hosp. of Mechanicsburg/AETNA Life & Cas.)*, 158 Pa. Commw. 313, 631 A.2d 804, 805-06 (Pa. Cmwlth. 1993).[6] Notably, if UPMC had petitioned for utilization review, UPMC would have retained the burden throughout that process of proving that the challenged medical treatment was unreasonable or unnecessary. *See Topps Chewing Gum v. Workers' Comp. Appeal Bd. (Wickizer)*, 710 A.2d 1256, 1260-61 (Pa. Cmwlth. 1998).

In *Crozer Chester II*, the employer issued a medical-only NCP voluntarily accepting liability for a claimant's work injury in the form of an umbilical hernia. *Crozer Chester Med. Ctr. v. Dep't of Lab. and Indus. Bureau of Workers' Comp. Health Care Servs. Rev. Div.*, 955 A.2d 1037, 1038 (Pa. Cmwlth. 2008) (*Crozer Chester I*), *aff'd Crozer Chester II*. The claimant **[**17]** underwent surgery to repair the hernia, but the insurer neither paid the billed cost of the surgery nor issued a written denial of liability for payment.[7] *Id.* The provider performing the surgery filed an application for fee review, which was denied as premature on the basis of "an outstanding issue of liability/compensability of the alleged injury." *Id.* Following denial of its request for a *de novo* administrative fee review hearing, the provider filed a petition for review in *mandamus* with this Court, seeking to compel the Hearing Office to consider the merits of its fee review application. *Id.* The Commonwealth Court denied the *mandamus* petition on the basis that the provider was "not attempting to enforce a right which has been established beyond peradventure, but [was] seeking to have [the] Court direct the Department to determine the issue of liability in [the provider's] favor." *Id.* at 1042-43. In *Crozer Chester II*, our **[*483]** Supreme Court affirmed, holding that the provider

> did not have a clear right to a decision of its fee review application on the merits because: (1) [it] alleged that [the insurer] disputed liability by refusing payment; and (2) [the provider] challenged the propriety of [the insurer's] **[**18]** denial rather than the amount or timeliness of payment for a particular treatment.

Crozer Chester II, 22 A.3d at 199. The *Crozer Chester II* Court reasoned:

> [I]t is apparent from [the provider's] *mandamus* petition that the present dispute is not capable of resolution through the Section 306(f.1)(5) fee review process. ***HN6***[⬆] Fee review is a process for medical care providers to dispute "the amount or timeliness" of an insurer's payment for a particular treatment, which are relatively simple matters. 77 P.S. § 531(5). But, [the provider's] petition contains no allegations that the medical fee had not been paid timely or had not been calculated in accordance with the compensation fee schedule or medical billing protocols. *See* 34 Pa. Code §§ 127.208, 127.210 (timeliness provisions);

---

[6] Even when a claimant receives medical treatment for new symptoms arising from a compensable work injury, where the connection between those symptoms and the work injury is obvious, the employer retains the burden of establishing that the new symptoms and corresponding treatment are not causally related to the work injury. *See Kurtz v. Workers' Comp. Appeal Bd. (Waynesburg Coll.)*, 794 A.2d 443, 447 (Pa. Cmwlth. 2002). However, when this connection is not obvious, the claimant bears the burden. *Id.* at 448. Here, neither Employer nor UPMC alleges that the disputed medication was prescribed to treat new symptoms that were not obviously related to Claimant's work injury.

[7] "If payment of a bill is denied entirely, insurers shall provide a written explanation for the denial." WC Regul. 127.209(a), 34 Pa. Code § 127.209(a).

> 127.101-127.135, 127.151-127.162, 127.205-127.207 (amount calculation provisions). [The provider] is seeking, instead, to establish the broader legal proposition that [insurer's] failure to pay was unwarranted and that the Department's fee review personnel were obliged to make that determination. Such a decision is outside the scope of what is designed to be a simple fee review process.

Id. at 197 (footnote omitted); *see also Crozer Chester I*, 955 A.2d at 1042 (holding that provider "fail[ed] to plead a legally cognizable claim in *mandamus*," where provider "[was] not attempting to enforce a right which **[**19]** has been established beyond peradventure, but [was] seeking to have this Court direct the Department to determine the issue of liability in [provider's] favor"). By contrast, here, the issue is whether UPMC's "causal relatedness" denial rendered Pharmacy's fee review application premature under WC Regulation 127.255, 34 Pa. Code § 127.255, not whether either party impermissibly sought to compel the exercise of the fee review office's discretion.

Further, in *Crozer Chester II*, the provider argued in its *mandamus* petition that this Court should compel the Department to consider the merits of its fee review application on the basis that the employer's "open" NCP constituted an unequivocal admission of liability for the claimant's injury. *See Crozer Chester II*, 22 A.3d at 192. Here, however, the issue is whether UPMC's "causal relatedness" denial—not the parties' NCP—rendered Pharmacy's fee review applications premature. *See id.* at 197 (citing *Cath. Health Initiatives v. Heath Fam. Chiropractic*, 720 A.2d 509, 511 (Pa. Cmwlth. 1998); WC Regul. 127.255, 34 Pa. Code § 127.255) (holding that an "'open' NCP simply cannot be construed as compelling a fee review on the merits if an insurer, rightly or wrongly, refuse[s] payment").

We acknowledge that, in a footnote in *Crozer Chester II*, the Pennsylvania Supreme Court suggested that WC Regulation 127.255(1), 34 Pa. Code § 127.255(1), might be susceptible to a reading **[**20]** that would allow disputes regarding liability for the prescribed treatment, in addition to denials of liability for the alleged work injury, to serve as bases for deeming fee applications prematurely filed. *See Crozer Chester II*, 22 A.3d at 194 n.5. The Supreme Court observed:

> We recognize that the language of Regulation 127.255(1) [regarding when a fee review application shall be deemed prematurely filed] appears to contain a latent ambiguity insofar as it refers to the **[*484]** insurer denying "liability for the alleged work injury." *See* 34 Pa. Code § 127.255. ***HN7***[⬆] Indeed, Section 306(f.1)(5) of the Act, which the regulation addresses, indicates that it is sufficient if the insurer denies liability for a "particular treatment," as explained further *infra*. *See* 77 P.S. § 531(5); [Section 435 of the Act, added by the Act of February 8, 1972, P.L. 25,] 77 P.S. § 991(a)(v) (Department to promulgate regulations "reasonably calculated to . . . explain and enforce the provisions of th[e] [A]ct"). In this case, the Department is interpreting the Regulation consistently with the Act, as required, and there is no issue before us regarding the overall validity of Regulation 127.255(1) in light of the latent ambiguity. *See* 77 P.S. § 991(a) (Department to promulgate regulations "consistent with th[e] [A]ct").

Crozer Chester II, 22 A.3d at 194 n.5.

However, that footnote does not govern this

dispute. We construe the Court's reference to a "latent ambiguity" **[**21]** between subsections (1) and (2) of WC Regulation 127.255, 34 Pa. Code § 127.255, as pertaining to circumstances where, for instance, an employer has denied liability for the injury early on and although that denial may be the subject of claim petition litigation, the employer is not yet responsible for medical bills. Thus, an employer or insurer would be denying liability for both the work injury and any billed treatment pending resolution of the claim petition, apparently implicating both subsections (1) and (2) of the above-cited regulation to render fee review premature.[8] *See id.*; *Armour Pharmacy v. Bureau of Workers' Comp. Fee Rev. Hearing Off. (Wegman's Food Mkts., Inc.)*, 206 A.3d 660, 665-66 (Pa. Cmwlth. 2019) (stating that "an employer's liability for a claimant's work injury must be established before the fee review provisions can come into play").

HN8[] Moreover, as footnote 5 of *Crozer Chester II* points out, Section 306(f.1)(5) specifically provides that an insurer's dispute regarding a "particular treatment" may *suspend the 30-day payment period. See* Section 306(f.1)(5) of the Act, 77 P.S. § 531(5). Critically, this portion of Section 306(f.1)(5) does not pertain to instances where the employer has denied liability for the injury. It governs challenges raised through the utilization review process, which can only arise after the employer has accepted liability for the underlying injury. *See id.* (providing that employer or insurer shall make payment for treatment provided pursuant **[**22]** to the Act "*unless the employer or insurer disputes the reasonableness or necessity of the treatment provided [through the utilization review process] pursuant to paragraph (6)*") (emphasis added). Expanding WC Regulation 127.255(1) by incorporating utilization review provisions (the subject of subsection 2) would render meaningless any distinction between subsection (1) (denial of liability for alleged work injury) and subsection (2) (treatment disputed through utilization review), as both bases for deeming a fee application premature would then include denials of liability for treatment pursued through the utilization review process.[9]

[*485] Accordingly, we conclude that none of the conditions in WC Regulation 127.255 have been met. Therefore, the Hearing Office correctly determined that Pharmacy's fee review petitions were not premature, and we affirm.

CHRISTINE FIZZANO CANNON, Judge

ORDER

AND NOW, this 15th day of December, 2022, the April 23, 2021 decision of the Bureau of Workers' Compensation Fee Review Hearing

[8] In that instance, the medical provider assumes the risk that the claimant's claim petition may be unsuccessful and the provider may not be paid for treatment.

[9] We further note that footnote 5 of *Crozer Chester II* constitutes non-binding *dictum. See In re L.J.*, 622 Pa. 126, 79 A.3d 1073, 1081 (Pa. 2013) (holding that a footnote in a separate case constituted "non-binding *dict[um]*" to which "*stare decisis* did not apply," where "the passage was not necessary to the outcome of the case" and "the majority . . . simply volunteered the discussion" when "the issue was not litigated by the parties"). Moreover, the "latent ambiguity" referenced by the Court in that footnote is not of concern here as UPMC issued an NCP that remains open, thereby foreclosing its ability to render fee review premature by means of WC Regulation 127.255(1), 34 Pa. Code § 127.255(1), absent some further action by Employer to rescind, amend, or terminate the NCP. *See Mahon v. Workers' Comp. Appeal Bd. (Expert Window Cleaning & State Workers' Ins. Fund)*, 835 A.2d 420, 426 (Pa. Cmwlth. 2003); *Beissel v. Workmen's Comp. Appeal Bd. (John Wanamaker, Inc.)*, 502 Pa. 178, 465 A.2d 969, 971-72 (1983). Thus, subsection (2) of WC Regulation 127.255 constituted UPMC's sole means of temporarily forestalling the fee review process. *See* 34 Pa. Code § 127.255(2).

Office is AFFIRMED.

CHRISTINE FIZZANO CANNON, Judge

Dissent by: RENÉE COHN JUBELIRER

Dissent

DISSENTING OPINION BY PRESIDENT JUDGE COHN JUBELIRER

The Workers' Compensation Act[1] (Act) establishes **[**23]** three distinct "tracks" for litigating issues related to the payment of medical treatment and services that arise under its provisions: (1) the fee review process, whereby relatively simple questions regarding the timing and amount of medical payments are resolved by administrative staff; (2) the Utilization Review (UR) process, whereby more complicated questions regarding the medical reasonableness and necessity of a causally-related medical treatment or service are resolved by medical providers within the medical specialty of the prescribing medical provider; and (3) the petition process, whereby the most complicated and disputed issues, including questions of liability and causal relatedness, are resolved by specialized Workers' Compensation Judges (WCJs). *See Crozer Chester Med. Ctr. v. Dep't of Lab. & Indus., Bureau of Workers' Comp., Health Care Servs. Rev. Div.*, 610 Pa. 459, 22 A.3d 189, 195-98 (Pa. 2011) (*Crozer Chester II*[2]) (describing the various tracks of litigation under the Act).

In *Workers' First Pharmacy Services, LLC v. Bureau of Workers' Compensation Fee Review Hearing Office*, 225 A.3d 613 (Pa. Cmwlth. 2020) (*Workers' First*), this Court, surmising there was a gap in the Act's procedures, altered the boundaries of these tracks and established a procedure that is not supported by the plain language of Section 306(f.1) of the Act, 77 P.S. § 531, the Bureau of Workers' Compensation's (Bureau) Regulations (Regulations), or precedent. The Court then reiterated *Workers' **[**24]** First*'s holding in *Omni Pharmacy Services, LLC v. Bureau of Workers' Compensation Fee Review Hearing Office*, 241 A.3d 1273 (Pa. Cmwlth. 2020) (*Omni Pharmacy*). The Majority relies on *Workers' First* and *Omni Pharmacy* to affirm the decision of the Bureau of Workers' Compensation Medical Fee Review Hearing Office (Hearing Office) in this matter. *UPMC Benefit Mgmt. Servs., Inc. d/b/a UPMC Work Partners v. United Pharmacy Servs. (Bureau of Workers' Comp. Fee Rev. Hearing Off.)* (*UPMC Benefit Mgmt. Servs.*), _ A.3d _, _ (Pa. Cmwlth., No. 558 C.D. 2021, filed December 15, 2022), slip op. at 9-12. Because I do not believe that it is **[*486]** for this Court to add language or requirements to the Act that the General Assembly did not include, I must, respectfully, dissent.

The matter presently before the Court involves the Fee Review Applications of United Pharmacy Services (Pharmacy) that UPMC Benefit Management Services, Inc. d/b/a UPMC Work Partners (UPMC), denied as not being related to the work-related injury. A Bureau Fee Review Hearing Officer found the Fee Review Applications were not premature, pursuant to *Workers' First* and *Omni Pharmacy*, because UPMC did not challenge payment for the treatment via the UR process. The Majority affirms this determination.

---

[1] Act of June 2, 1915, P.L. 736, *as amended*, 77 P.S. §§ 1-1041.4, 2501-2710.

[2] *Crozer Chester II* affirmed a single-judge opinion of this Court in *Crozer Chester Medical Center v. Department of Labor and Industry, Bureau of Workers' Compensation, Health Care Services Review Division*, 955 A.2d 1037 (Pa. Cmwlth. 2008).

However, because neither Section 306(f.1), the Regulations, nor precedent support the conclusion that the UR process was **intended** to address **causation-based** challenges, Pharmacy's Fee Review Applications were properly dismissed as premature in the first instance pursuant to Section 127.255(1) of the Regulations, 34 Pa. Code § 127.255(1).

Judicial decisions must be tethered to and consistent **[**25]** with the statutory provisions governing the issue before the Court, as the goal is to ascertain and effectuate the intent of the General Assembly. Section 1921(a) of the Statutory Construction Act of 1972, 1 Pa.C.S. § 1921(a); *Commonwealth v. Walter*, 625 Pa. 522, 93 A.3d 442, 450 (Pa. 2014). At issue here, as it was in *Workers' First* and *Omni Pharmacy*, is Section 306(f.1)(5) and (6) of the Act. Section 306(f.1)(5) and (6) expressly establishes two of the aforementioned tracks of litigation relevant to the payment of a claimant's medical bills: (1) the fee review process, whereby the provider can challenge the amount and/or timeliness of an insurer's payment; and (2) the UR process, whereby an employer or insurer can challenge the reasonableness and necessity of a particular treatment. [4]Section 306(f.1)(5) and (6) provides, in pertinent part, as follows:

> (5) The employer or insurer shall make payment and providers shall submit bills and records in accordance with the provisions of this section. **All payments to providers** for treatment provided pursuant to this act **shall be made within thirty (30) days** of receipt of such bills and records **unless the employer or insurer disputes the reasonableness or necessity of the treatment provided pursuant to paragraph (6)**. . . . . A **provider** who has submitted the reports and bills required by this section and **who disputes the amount or timeliness of the payment from [**26] the employer or insurer shall file an application for fee review** with the [D]epartment [of Labor and Industry (Department)] no more than thirty (30) days following notification of a disputed treatment or ninety (90) days following the original billing date of treatment. **If the insurer disputes the reasonableness and necessity of the treatment pursuant to paragraph (6), the period for filing an application for fee review shall be tolled** as long as the insurer has the right to suspend payment to the provider pursuant to the provisions of this paragraph. . . . .
>
> (6) Except in those cases in which a [WCJ] asks for an opinion from peer review under [S]ection 420 [of the Act], [77 P.S. §§ 831, 832,] **disputes as to reasonableness or necessity of treatment by a health care provider shall [*487] be resolved in accordance with the following provisions**:
>
> > (i) The **reasonableness or necessity of all treatment provided by a health care provider under this act may be**

[4] The Majority asserts that Claimant may not have borne the burden of proving the causal relationship between the treatment and accepted work injury, citing *Kurtz v. Workers' Compensation Appeal Board (Waynesburg College)*, 794 A.2d 443 (Pa. Cmwlth. 2002), because UPMC has not alleged that the disputed treatment was prescribed to treat new symptoms that were not obviously related to the work injury. *UPMC Benefit Mgmt. Servs.*, __ A.3d at __ n.6, slip op. at 13 n.6. However, this does not appear to be a situation where a claimant had been treating the injury and developed **new** symptoms, obvious or not, for which new treatment was prescribed. Claimant was injured on October 21, 2019, the prescription was written three months later, on January 22, 2020, and it was the first three bills for the prescribed medication that were denied as not being related to the work injury. Notably, while the prescription states to apply the medicine "to [the] affected area two-four (2-4) time daily as needed," it does not describe what the "affected area" is. (Reproduced Record at 9a.) Thus, I am not persuaded that the burden had shifted in this matter.

> **subject to prospective, concurrent or retrospective [UR]** at the request of an employe, employer or insurer. . . . . U[R] of all treatment rendered by a health care provider shall be performed by a provider licensed in the same profession and having the same or similar specialty as that **[**27]** of the provider of the treatment under review. . . .
>
> . . . .

77 P.S. § 531(5)-(6)(i) (emphasis added). The Regulations provide additional guidance on these two tracks of litigation. Per those Regulations, if a provider files a fee review application that challenges the timeliness or amount of a payment, such application **will be returned** as "premature" if: "(1) [t]he insurer denies liability for the alleged work injury"; or "(2) [t]he insurer has filed a request for [UR] of the treatment . . . ."; or "(3) [t]he 30-day period allowed for payment has not yet elapsed . . . ." 34 Pa. Code § 127.255. Our Supreme Court has interpreted subsection (1) to include disputes of liability not only for the work injury itself but also liability for "a 'particular treatment'" being provided for an established work injury. *Crozer Chester II*, 22 A.3d at 194 n.5 (quoting 77 P.S. § 531(5)). Such challenges can include, as here, that "the billed treatment **is not related** to the accepted work-related injury . . . ." *Id.* at 195 (emphasis added). Thus, per this Regulation, as interpreted by our Supreme Court, if an insurer disputes liability for a particular treatment, a fee review application should be returned as premature and **the question of liability must be resolved elsewhere**. This was the basis upon which Pharmacy's Fee Review **[**28]** Applications were initially rejected as being premature — a denial of liability because the billed treatment was not related to the accepted work injury.

A second reason for returning a fee review application as premature is if an insurer questions whether the particular treatment is reasonable and necessary for the work injury by filing for UR as provided for by Section 306(f.1)(5) and (6). The Regulations impose limits on what may be considered in the UR — specifically, UR Organizations (UROs) are **prohibited** from deciding, among other issues, "[t]he causal relationship between the treatment under review and the employe's workrelated injury." 34 Pa. Code § 127.406(b)(1). Indeed, it is the duty of a reviewer to "**assume** the existence of a **causal relationship** between the treatment under review and the employe's work-related injury." 34 Pa. Code § 127.470(b) (emphasis added). Thus, the UR process focuses only on the medical reasonableness and necessity of the billed treatment, which is presumed to be causally related to the work injury.

Neither Section 306(f.1) nor the Regulations **contain any language authorizing** the consideration and resolution of **causation-based challenges or denials of payment** within the fee review or UR processes. The fee review process is expressly limited **[**29]** to reviewing the amount and timeliness of payments and has a "very narrow scope within the broader legislative and regulatory scheme of compensating claimants for work-related injuries." *Crozer Chester II*, 22 A.3d at 196. The UR process is similarly limited in its scope to determining whether the treatment in question is medically reasonable and necessary for the work injury and **assumes** that **a causal connection exists** between the treatment and the work injury. After reviewing these processes, as well as the third track, the petition process, the Supreme Court **[*488]** has observed that "the General Assembly directed that **most disputed compensation issues be**

litigated between claimants and insurers before skilled [WCJs] in the first instance." *Id.* (emphasis added). Accordingly, disputed compensation issues, such as denials of liability based on lack of causation, should be asserted through the third track of litigation, the petition process, in which specialized WCJs resolve those issues in litigation between claimants and insurers. *Id.* The procedure set forth in *Workers' First* is not consistent with these established processes and is based on a misinterpretation of *Crozer Chester II*.

While *Workers' First* quoted the above statutory **[**30]** and regulatory language and acknowledged the limited scope of the fee review and UR processes, its ultimate decision, that **causation-based challenges** where there is an accepted injury **must be raised** through **the UR process** and the failure to do so **precludes dismissal** of a provider's **fee review application as premature**, 225 A.3d at 620-21, is not tethered to or consistent with that language or those limitations. The Court addressed a denial of payment in *Workers' First* that was based on a lack of causation. *Workers' First* nonetheless held that this issue was "for the [URO] to sort [] out," reasoning that "[i]f the compound cream was prescribed for a non-work-related injury of [the c]laimant, *a fortiori* it is not reasonable or necessary for treatment of [the] accepted work injury." *Id.* Faced with what appeared to be a causation challenge that would preclude UR, the Court recharacterized the denial as being "**just another way** of stating that the compound cream was not a reasonable or necessary 'procedure' for treating [the c]laimant's 'diagnosis.'" *Id.* at 621 (emphasis added). The Majority attempts to "clarify" that *Workers' First* does not hold that a liability-based challenge can be made only through the UR process, **[**31]** but, in cases where an insurer argues that a fee review application is premature, the "dispute regarding the causal connection between the prescribed treatment and the underlying work injury **must be reframed** as a challenge to the reasonableness and necessity of the treatment through the [UR] process." *UPMC Benefit Mgmt. Servs.*, __ A.3d at __ n.5, slip op. at 11 n.5 (emphasis added). However, the emphasized statements in *Workers' First* and the Majority conflate two concepts: whether a treatment is causally connected to an accepted work injury is not the same issue as whether a prescribed treatment is reasonable and necessary for the accepted work injury. Indeed, *Workers' First*'s holding has been criticized in legal commentary because "[l]ack of causation is not equivalent to lack of reasonableness and necessity." David B. Torrey & Andrew E. Greenburg, 7 West's Pa. Prac., Workers' Comp. § 9:91.50 (2020).

Workers' First relied on the Supreme Court's observation in *Crozer Chester II* that an employer questioning liability for a particular treatment can file a modification petition to change the scope of the accepted work injury or seek UR of the treatment. *Workers' First*, 225 A.3d at 620 (citing *Crozer Chester II*, 22 A.3d at 195). In relying on that observation to support its conclusion, *Workers' First* treats these alternatives as interchangeable, which they **[**32]** are not. In *Crozer Chester II*, the Supreme Court treated modification petitions and UR requests as **distinct** challenges with **different** procedures for resolving the **different** issues raised. Challenges to the reasonableness and necessity of a treatment for the accepted work injury are to be raised in the UR process, while assertions that the treatment is not related to, or causally connected to, the accepted work injury **are to be raised "within the context [*489] of claimant-insurer litigation**." *Crozer Chester II*, 22 A.3d at 195-98 (emphasis

added). Notably, under the Act, a claimant bears the burden to prove treatment is causally related to a work injury before an employer is responsible for that treatment.[5] Causation-based denials should thus be "properly viewed as the province of specially qualified [WCJs]." *Id.* at 198. However, because causation is presumed in the UR process, that process is ill-suited to resolve disputes where causation is the issue. Respectfully, *Workers' First* turns the process on its head by directing UROs to resolve an issue that they are, under the Regulations, prohibited from addressing under the guise of "reframing" the issue. *UPMC Benefit Mgmt. Servs.*, __ A.3d at __ n.5, slip op. at 11 n.5. *Workers' First* thus places causation-based challenges to liability within the ambit **[**33]** of the UR process, without statutory, regulatory, or precedential support. Respectfully, *Omni Pharmacy*, which applied *Workers' First* to similar facts, merely perpetuates this error, as does the Majority.

The Majority holds that *Crozer Chester II* is inapposite because "[t]he portion of *Crozer Chester II* cited by UPMC merely explains that providers may not be parties to a [UR] dispute between the claimant and employer and, in practice, the claimant brings the [UR] petition on the provider's behalf." *UPMC Benefit Mgmt. Servs.*, __ A.3d at __, slip op. at 13. Although the Majority reads the Supreme Court's language as merely explanatory and appears to agree with Pharmacy that *Crozer Chester II* should be read narrowly because it involved a mandamus action, I disagree with such a narrow reading where the Supreme Court's analysis expressly addressed legal issues and principles that are relevant and applicable **outside** the mandamus context. Moreover, the Majority concludes that the footnote in *Crozer Chester II* that recognized a latent ambiguity in Section 127.255(1) of the Regulations due to that provision's focus on denials of liability for the alleged work injury, where Section 301(f.1)(5) refers to denying "liability for a 'particular treatment'," does not govern **[**34]** this matter because Section 127.255(1) should be read as applying in situations only where the employer denies liability for the alleged work injury and any treatment until the resolution of a claim petition. *UPMC Benefit Mgmt. Servs.*, __ A.3d at __, slip op. at 16-17. I believe this reading overlooks the Supreme Court's subsequent discussion that distinguishes reasonableness and necessity challenges from challenges **[*490]** to liability for a particular treatment as not being related to an accepted injury. *Crozer Chester II*, 22 A.3d at 195.

As the Supreme Court stated, "[i]n cases in which **liability for a particular treatment is at issue**, the **claimant**, not the medical provider, **must pursue compensation** before a WCJ **in the regular course**." *Id.* (emphasis added). Even where there is an "open" Notice of Compensation Payable, that agreement may be "binding with respect to liability for the injury," but it "is **not dispositive**" on **liability** for a **particular treatment**, does not bar an insurer from disputing liability for a particular treatment, and cannot "compel[] a fee review on the merits if an insurer, rightly or wrongly, refused payment." *Id.* at 197 (emphasis added). Questions regarding "whether a [provider is] entitled to a payment **at all**," which is what a causation-based challenge involves, are "properly viewed **[**35]** as the province of specially qualified [WCJs], to be rendered in the context of claimant-insurer litigation." *Id.* at

[5] It appears that *Workers' First* may have been decided, in part, based on the egregious facts therein, where the actions of the claimant and the employer, by settling the underlying workers' compensation claim without agreeing to whether the treatment was related to the work injury, left the provider in that case with no options to protect its interests. 225 A.3d at 615.

198 (emphasis added). I would conclude that *Workers' First, Omni Pharmacy*, and now the Majority, are inconsistent with *Crozer Chester II*.

Finally, Pharmacy argues, as the pharmacy had in *Workers' First*, that the Act does not provide a direct means through which a provider can challenge an insurer's causation-based denial and, therefore, infringes upon its due process rights. (Pharmacy's Brief at 20.) To the extent that providers alone, without a claimant's involvement, cannot challenge a causation-based denial of payment under Section 306(f.1), this is what the plain language of the Act provides and there may be reasons why the Act was crafted that way. If providers alone, without a claimant, require a process to challenge a causation-based denial of payment under the Act, it is the province of the General Assembly, and not this Court, to craft one. It bears emphasizing that "courts have no authority to add or insert language into a statute and should not, through interpretation, add a requirement that the General Assembly did not include." *Township of Washington v. Township of Burrell*, 184 A.3d 1083, 1089 (Pa. Cmwlth. 2018) (internal quotation and citation omitted). This is particularly **[**36]** important in legislation in which the interests of injured workers, employers/insurers, medical providers, and all stakeholders are balanced and considered.

Such view is confirmed, I believe, by our Supreme Court's recent decision in *Keystone RX LLC v. Bureau of Workers' Compensation Fee Review Hearing Office (CompServices, Inc./Amerihealth Casualty Services)*, 265 A.3d 322 (Pa. 2021) (*Keystone RX*). While Pharmacy contends that *Keystone RX* has no bearing on this matter, and the Majority holds that *Keystone RX* does not preclude affirming, I disagree. *Keystone RX* offers insight into the Supreme Court's view of this Court's recent interpretations of the Act as, in some cases, exceeding its authority. In *Keystone RX*, the Supreme Court questioned this Court's "engraft[ing] onto the Act a requirement" not in the Act in order "[t]o remedy [a] perceived infirmity" related to non-treating providers not receiving due process under the Act. 265 A.3d at 329. In disagreeing with this Court's determination that due process required non-treating providers be given notice and an opportunity to intervene in UR proceedings to protect their property interests, our Supreme Court held that, first, there was no statutory support for allowing intervention, and second, when an insurer invokes the UR process, the non-treating provider is not entitled to payment unless and until the UR process finds the treatment reasonable and **[**37]** necessary. *Id.* at 333. If the insurer is successful, "the Act makes **[*491]** clear that the non-treating provider does not have a constitutionally-protected property interest in goods or services that it dispensed." *Id.* As there is no protected property interest when the UR process is invoked, due process is not implicated. *Id.* In his concurring opinion, Justice Wecht wrote separately to expressly disapprove of the "judicial re-writing of the Act," which would "usurp the General Assembly's policy-making authority and exceed the parameters of legislation by engrafting statutory requirements that the General Assembly chose to omit." *Id.* at 333-34 (Wecht, J., concurring).

Similar to the effect of the invocation of the UR process discussed in *Keystone RX*, the effect of an insurer challenging the causal relationship between a treatment and a work injury is that the non-treating provider has no entitlement to payment unless and until the causal relationship is established. This supports the conclusion that

the fee review application is premature because, if no causal relationship is established, "the Act makes clear that the non-treating provider does not have a constitutionally-protected property interest in goods or services that **[**38]** it dispensed." *Keystone RX*, 265 A.3d at 333. Further, similar to this Court's language in *Keystone RX* that engrafted due process provisions into the UR process so as to allow non-treating providers to participate, *Workers' First*'s inclusion of causation issues into the UR process, absent statutory authorization, appears to be the type of "judicial rewriting" of which Justice Wecht disapproved. *Keystone RX*, 265 A.3d at 333 (Wecht, J., concurring). As Justice Wecht explained in his concurring opinion, "[e]ntities left out . . . are free to petition the legislature for redress" but such decisions "are for the policy-making branches. They are not for the judiciary." *Id.* at 334. Accordingly, I would conclude that *Workers' First*, *Omni Pharmacy*, and the Majority are inconsistent with our Supreme Court's recent observations in *Keystone RX*.

For these reasons, respectfully, I would reverse and, therefore, must dissent to the thoughtful Majority opinion.

RENÉE COHN JUBELIRER, President Judge

Workers' First Pharm. Servs., LLC v. Bureau of Workers' Comp. Fee Review Hearing Office

Commonwealth Court of Pennsylvania

November 12, 2019, Argued; January 16, 2020, Decided; January 16, 2020, Filed

No. 901 C.D. 2018

Reporter

225 A.3d 613 *; 2020 Pa. Commw. LEXIS 70 **; 2020 WL 236746

Workers' First Pharmacy Services, LLC, Petitioner v. Bureau of Workers' Compensation Fee Review Hearing Office (Gallagher Bassett Services), Respondent

Prior History: [1]** Appealed from No. DSP-7850256-2. State Agency: Bureau of Workers' Compensation.

Case Summary

Overview

HOLDINGS: [1]-The Hearing Office erred finding the pharmacy's fee review petition was premature based on the employer having accepted liability for the claimant's work injury and not seeking a utilization review to challenge the compound cream as the employer was obligated to seek utilization review upon receipt of the pharmacy's invoice and by failing to do so left the pharmacy without a forum to challenge the employer's refusal to reimburse it for the compound cream it dispensed to the claimant in violation of its due process rights; [2]-The court held that a Compromise and Release agreement, to which the pharmacy was not a party, could not be used to deprive a provider of the review procedures and excuse the employer from paying the provider.

Outcome

Determination vacated; case remanded to Hearing Office for further proceedings.

LexisNexis® Headnotes

Workers' Compensation & SSDI > Administrative Proceedings > Hearings & Review

Workers' Compensation & SSDI > Administrative Proceedings > Judicial Review > Standards of Review

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits

HN1[] **Administrative Proceedings, Hearings & Review**

The Commonwealth Court of Pennsylvania's review in workers' compensation medical fee review cases determines whether constitutional rights were violated, whether an error of law was committed, or whether the necessary findings of fact were supported by substantial evidence. Regarding questions of law, the court's scope of review is plenary and the court's standard of review is de novo.

Constitutional Law > ... > Fundamental Rights > Procedural Due Process > Scope of Protection

***HN2*[] Procedural Due Process, Scope of Protection**

The Due Process Clause of the Fourteenth Amendment states that no State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws. U.S. Const. amend. XIV, §1. The Pennsylvania Constitution also provides that protection in Pa. Const. art. I, § 9.

Workers' Compensation & SSDI > Administrative Proceedings > Costs & Attorney Fees

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits

Workers' Compensation & SSDI > Administrative Proceedings > Hearings & Review

***HN3*[] Administrative Proceedings, Costs & Attorney Fees**

The Workers' Compensation Act, 77 Pa. Stat. Ann. § 531(5), requires employers to make prompt payment on provider invoices for reasonable and necessary medical treatment of a claimant's work injury, and it establishes procedures for resolving disputes between a provider and an employer about whether the treatment actually meets that standard.

Business & Corporate Compliance > ... > Workers' Compensation & SSDI > Compensability > Course of Employment

Workers' Compensation & SSDI > Administrative Proceedings > Costs & Attorney Fees

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits

Workers' Compensation & SSDI > Administrative Proceedings > Hearings & Review

***HN4*[] Workers' Compensation, Course of Employment**

The Department of Labor and Industry's (Department) cost containment regulation, 34 Pa. Code § 127.406(b)(1), states that utilization review does not decide the causal relationship between the treatment under review and the employe's work-related injury. 34 Pa. Code § 127.406(b)(1). The regulation also states that in medical only cases, when an insurer is paying for an injured worker's medical treatment but has not admitted liability for a work-related injury, the insurer may still seek review of the reasonableness or necessity of the treatment by filing a request for utilization review. 34 Pa. Code § 127.405(a).

Workers' Compensation & SSDI > Administrative Proceedings > Costs & Attorney Fees

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits

Workers' Compensation &

SSDI > Administrative Proceedings > Hearings & Review

***HN5*[] Administrative Proceedings, Costs & Attorney Fees**

Where an employer challenges a provider's treatment as neither reasonable nor necessary for a work injury, it must seek utilization review pursuant to Section 301(f.1)(6) of the Act, 77 Pa. Stat. Ann. § 531(6). Until the utilization review determination is issued, the employer may suspend payment to the provider. Section 301(f.1)(5), 77 Pa. Stat. Ann. § 531(5). Where a provider does not receive payment within 30 days (and payment has not been stayed by an employer's utilization review request, the provider may file a fee review petition pursuant to Section 301(f.1)(5) of the Act, 77 Pa. Stat. Ann. § 531(5).

Workers' Compensation & SSDI > Administrative Proceedings > Costs & Attorney Fees

Workers' Compensation & SSDI > Administrative Proceedings > Hearings & Review

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits

***HN6*[] Administrative Proceedings, Costs & Attorney Fees**

A fee review proceeding is not the mechanism for establishing that a claimant has sustained a work-related injury or the scope of the work injury. As the Commonwealth Court of Pennsylvania has explained: the fee review process presupposes that liability has been established, either by voluntary acceptance by the employer or a determination by a Workers' Compensation Judge. Neither the Act nor the medical cost containment regulations provide any authority for a fee review officer to decide the issue of liability in a fee review proceeding. 34 Pa. Code § 127.255(1) states that an application for fee review filed by a provider is premature and will be returned if the insurer denies liability for the alleged work injury. The issue for the fee review officer is the amount and timeliness of the payment made by an insurer. 34 Pa. Code § 127.251.

Workers' Compensation & SSDI > Administrative Proceedings > Hearings & Review

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits

***HN7*[] Administrative Proceedings, Hearings & Review**

The medical cost containment regulation, 34 Pa. Code § 127.255, states that a fee review is premature in the following instances: (1) The insurer denies liability for the alleged work injury. (2) The insurer has filed a request for utilization review of the treatment under Subchapter C (relating to medical treatment review). (3) The 30-day period allowed for payment has not yet elapsed, as computed under 34 Pa. Code § 127.208 relating to time for payment of medical bills. A dispute about whether a claimant has a work injury, or the scope of that injury, must be litigated in accordance with the procedures of the Workers' Compensation Act, 77 Pa. Stat. Ann. §§ 1-1041.4, 2501-2710, for a claim petition proceeding. In a claim proceeding, the employee bears the burden of establishing a right to compensation and of proving all necessary elements to support an award.

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

***HN8*[] Medical Benefits, Authorized Treatment**

A compound cream prescribed to the claimant has previously been determined to be a reasonable and necessary treatment of the claimant's accepted work injury.

Constitutional Law > ... > Fundamental Rights > Procedural Due Process > Scope of Protection

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

Workers' Compensation & SSDI > Administrative Proceedings > Hearings & Review

Workers' Compensation & SSDI > Administrative Proceedings > Costs & Attorney Fees

***HN9*[] Procedural Due Process, Scope of Protection**

The Commonwealth Court of Pennsylvania has held that a Compromise and Release agreement, to which a provider is not a party, cannot be used to deprive a provider of the review procedures and excuse the employer from paying the provider. To hold otherwise would eviscerate Section 301(f.1)(5) and (6) of the Workers' Compensation Act, 77 Pa. Stat. Ann. § 531(6), and violate the due process of law guaranteed to providers.

Workers' Compensation & SSDI > Administrative Proceedings > Hearings & Review

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits

***HN10*[] Administrative Proceedings, Hearings & Review**

In Armour Pharmacy II, the fee review procedure is designed to determine the amount or timeliness of payment for medical treatment and that whether a pharmacy is a health care provider under the Workers' Compensation Act, 77 Pa. Stat. Ann. §§ 1-1041.4, 2501-2710, was beyond the scope of a fee review proceeding.

Workers' Compensation & SSDI > Administrative Proceedings > Hearings & Review

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits

***HN11*[] Administrative Proceedings, Hearings & Review**

34 Pa. Code § 127.255 provides that a fee review of non-payment of a provider invoice is premature only where the employer denies liability for the work injury; has requested utilization review; or 30 days has not yet elapsed.

Workers' Compensation & SSDI > Administrative Proceedings > Hearings & Review

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits

***HN12*[] Administrative Proceedings,**

Hearings & Review

A claimant may be under treatment for an array of medical problems, only some of which relate to the work injury. It is for the Utilization Review Organization to sort this out. If the compound cream is prescribed for a non-work-related injury of the claimant, a fortiori it is not reasonable or necessary for treatment of her accepted work injury. Under the Workers' Compensation Bureau's regulation, the Utilization Review Organization (URO) does not decide an issue about the causal relationship between the treatment and the employe's work injury. 34 Pa. Code §127.406(b)(1). On the other hand, the URO must decide the reasonableness or necessity of the treatment. 34 Pa. Code §127.406(a). The regulation is ambiguous. The mandate to determine reasonableness or necessity of the treatment cannot be sidestepped. That the treatment may be reasonable for a non-work-related injury is beyond the scope of utilization review, which may be the scope of utilization review, which may be the purpose of 34 Pa. Code §127.406(b)(1).

Workers' Compensation & SSDI > Administrative Proceedings > Hearings & Review

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits

HN13[⬇] **Administrative Proceedings, Hearings & Review**

An application for fee review is deemed premature in three circumstances: (1) where the insurer denies liability for the alleged work injury; (2) where the insurer has filed a request for utilization review; or (3) where the 30-day period insurer is allowed for payment of a provider's invoice has not yet elapsed. 34 Pa. Code §127.255.

Counsel: Daniel J. Siegel, Havertown, for Petitioner.

Alan M. Leff, Philadelphia, for Respondent.

Judges: BEFORE: HONORABLE MARY HANNAH LEAVITT, President Judge, HONORABLE CHRISTINE FIZZANO CANNON, Judge, HONORABLE BONNIE BRIGANCE LEADBETTER, Senior Judge. OPINION BY PRESIDENT JUDGE LEAVITT.

Opinion by: MARY HANNAH LEAVITT

Opinion

[*614] OPINION BY PRESIDENT JUDGE LEAVITT

Workers' First Pharmacy Services, LLC, (Pharmacy) petitions for review of an adjudication of the Bureau of Workers' Compensation (Bureau), Fee Review Hearing Office (Hearing Office) that vacated a determination of the Bureau's Medical Fee Review Section. At issue is Pharmacy's invoice for a compound cream that it **[*615]** dispensed to Adriana Lozano (Claimant) for treatment of a work injury, which Claimant's employer, Bayada Home Health Care, Inc. (Employer),[1] refused to pay. When the Medical Fee Review Section ordered Employer to pay Pharmacy's invoice, Employer appealed. The Hearing Office held that Pharmacy's fee review petition was premature; vacated the determination of the Medical Fee Review Section on Pharmacy's petition; and dismissed Employer's appeal of

[1] Employer is insured by Gallagher Bassett Services/Arch Insurance Company.

the directive to pay Pharmacy's **[**2]** invoice for the compound cream. Before this Court, Pharmacy asserts that the Hearing Office erred and has left it without a forum to challenge Employer's refusal to reimburse it for the compound cream it dispensed to Claimant, and this deprives Pharmacy of due process. We vacate and remand.

Background

On December 18, 2016, Claimant sustained a shoulder injury while working for Employer. Pursuant to the Workers' Compensation Act,[2] Employer issued a medical-only Notice of Temporary Compensation Payable (NTCP), accepting the work injury as a right shoulder strain. On June 16, 2017, Samuel Grodofsky, M.D., prescribed Claimant a compound cream, *i.e.*, Diclofenac 1.5% Topical Solution, for application to the "affected area 2-4 times daily[.]" Reproduced Record at 13a (R.R. __). On June 21, 2017, Pharmacy dispensed the compound cream to Claimant and billed Employer $4,869.99. Employer denied payment for the stated reason that the "diagnosis is inconsistent with the procedure." R.R. 11a.

On August 25, 2017, Pharmacy filed a fee review application. Pharmacy submitted a "Health Insurance Claim Form" reporting Claimant's address and insurance information. R.R. 9a. It also documented that **[**3]** Claimant received the compound cream on June 21, 2017, and the cost was $4,869.99. Additionally, Pharmacy submitted a copy of Dr. Grodofsky's prescription for the compound cream.

In the meantime, Claimant and Employer pursued litigation related to Claimant's work injury. On May 23, 2017, Claimant filed a penalty petition, alleging that Employer had violated the Act by unilaterally stopping Claimant's benefits as of January 4, 2017. On June 30, 2017, Employer filed a termination petition, alleging that Claimant had fully recovered from her work injury. On July 18, 2017, Claimant filed a review petition seeking to amend the description of her injury in the NTCP to include an acromioclavicular joint separation and a clavicular avulsion fracture. These petitions were assigned to a Workers' Compensation Judge (WCJ), who scheduled a hearing for August 23, 2017.

At that scheduled hearing, the parties requested the WCJ to approve their Compromise and Release (C & R) Agreement, by which Employer agreed to pay Claimant $15,000 to resolve any future medical or wage loss claims and any medical bills incurred prior to the date of the hearing that were related to the accepted work injury, which the **[**4]** C & R Agreement described as a "right shoulder strain." R.R. 34a. The WCJ approved the C & R Agreement on August 25, 2017.

On October 12, 2017, the Bureau's Medical Fee Review Section acted upon Pharmacy's fee review petition that had been filed on August 25, 2017, the same day the WCJ approved the C & R Agreement. The Medical Fee Review Section held that Employer was obligated to reimburse Pharmacy **[*616]** $4,455 plus interest from July 6, 2017. Employer requested a *de novo* hearing to contest the fee determination, arguing that the compound cream dispensed by Pharmacy had never been adjudicated as related to Claimant's work injury and, thus, Pharmacy's fee review application was premature. Pharmacy responded that

[2] Act of June 2, 1915, P.L. 736, *as amended*, 77 P.S. §§1-1041.4, 2501-2710.

Employer should have sought utilization review if it believed that the compound cream it dispensed was not related to Claimant's work injury. Dismissing Pharmacy's fee review application would leave it without a remedy and violate due process.

The Hearing Office found that Employer denied payment because of Employer's "belief that the bill for the [compound cream] is not related to the work injury." Adjudication, 6/7/2018, at 4, Finding of Fact No. 13; R.R. 108a. The Hearing Office **[**5]** cited Claimant's testimony from the C & R hearing that it was her understanding that the C & R Agreement obligated Employer to pay only those medical bills "related" to the work injury. *Id.*, Finding of Fact No. 14(a); R.R. 108a. However, there was no statement in the C & R Agreement that the compound cream dispensed by Pharmacy related to Claimant's work injury. Concluding that liability for the compound cream had to be established either by Employer's acceptance or a determination by a WCJ, the Hearing Office determined that Pharmacy's fee review petition was premature.

The Hearing Office vacated the Medical Fee Review Section's fee determination and dismissed Employer's request for a hearing on the fee determination.

Issues

Pharmacy has petitioned for this Court's review. On appeal, it raises two issues.[3] First, it asserts that the Hearing Office erred in dismissing Employer's request for a *de novo* hearing on the merits of the Medical Fee Review Section's determination that Employer had to pay Pharmacy's invoice. Pharmacy contends that its fee petition was not premature in light of the fact that Employer did not request utilization review of the treatment. Second, it argues that it violates **[**6]** due process not to provide Pharmacy a mechanism for challenging Employer's refusal to reimburse it for compound cream it dispensed to Claimant.[4]

This Court directed the parties to file supplemental briefs to address recent developments in the law with respect to the fee review process. The Court's order stated as follows:

> [T]he parties are directed to file supplemental briefs in the above-captioned matter addressing the applicability of **[*617]** *Armour Pharmacy v. Bureau of Workers' Compensation Fee Review Hearing Office (Wegmans Food Markets, Inc.)*, 206 A.3d 660 (Pa. Cmwlth. 2019) [*Armour Pharmacy II*].

Order of Commonwealth Court, 6/14/2019.

In its supplemental brief, Pharmacy argues that

---

[3] ***HN1***[] Our review in medical fee review cases determines whether constitutional rights were violated, whether an error of law was committed, or whether the necessary findings of fact were supported by substantial evidence. *Pittsburgh Mercy Health System v. Bureau of Workers' Compensation, Fee Review Hearing Office (U.S. Steel Corp.)*, 980 A.2d 181, 184 n.4 (Pa. Cmwlth. 2009). Regarding questions of law, our scope of review is plenary and our standard of review is *de novo*. *Sedgwick Claims Management Services, Inc. v. Bureau of Workers' Compensation, Fee Review Hearing Office (Piszel and Bucks County Pain Center)*, 185 A.3d 429, 433 n.2 (Pa. Cmwlth. 2018).

[4] ***HN2***[] The Due Process Clause of the Fourteenth Amendment states as follows:

> No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

U.S. CONST. amend. XIV, §1. The Pennsylvania Constitution also provides this protection. PA. CONST. art. I, §9.

Armour Pharmacy II established that the Hearing Office may address the threshold question of whether the compound cream dispensed by Pharmacy was, in fact, related to the accepted work injury. A contrary ruling would violate due process. Alternatively, Pharmacy argues that Employer had to file a utilization review petition if it believed that **[**7]** the compound cream Pharmacy dispensed to Claimant did not "relate to" the accepted work injury.

Workers' Compensation Act

HN3[⬆] The Act requires employers to make prompt payment on provider invoices for reasonable and necessary medical treatment of a claimant's work injury, and it establishes procedures for resolving disputes between a provider and an employer about whether the treatment actually meets that standard. Specifically, Section 301(f.1)(5) states:

> The employer or insurer shall make payment and providers shall submit bills and records in accordance with the provisions of this section. *All payments to providers for treatment provided pursuant to this act shall be made within thirty (30) days of receipt of such bills and records unless the employer or insurer disputes the reasonableness or necessity of the treatment provided pursuant to paragraph (6).* The nonpayment to providers within thirty (30) days for treatment for which a bill and records have been submitted shall only apply to that particular treatment or portion thereof in dispute; payment must be made timely for any treatment or portion thereof not in dispute. *A provider who has submitted the reports and bills required by this section and who disputes the* ***[**8]*** *amount or timeliness of the payment from the employer or insurer shall file an application for fee review with the department no more than thirty (30) days following notification* of a disputed treatment or ninety (90) days following the original billing date of treatment. If the insurer disputes the reasonableness and necessity of the treatment pursuant to paragraph (6), the period for filing an application for fee review shall be tolled as long as the insurer has the right to suspend payment to the provider pursuant to the provisions of this paragraph. Within thirty (30) days of the filing of such an application, the department shall render an administrative decision.

77 P.S. §531(5) (emphasis added). "Paragraph 6" states, in relevant part, as follows:

> *[D]isputes as to reasonableness or necessity of treatment by a health care provider shall be resolved in accordance with the following provisions*:
>
> > (i) The reasonableness or necessity of all treatment provided by a health care provider under this act may be subject to prospective, concurrent or retrospective utilization review at the request of an employe, employer or insurer. The department shall authorize utilization review organizations to perform utilization review **[**9]** under this act. Utilization review of all treatment rendered by a health care provider shall be performed by a provider licensed in the same profession and having the same or similar specialty as that of the provider of the treatment under review.

77 P.S. §531(6) (emphasis added).

HN4[⬆] The Department of Labor and Industry's (Department) cost containment

regulation states that utilization review does **[*618]** "not decide" the "causal relationship between the treatment under review and the employe's work-related injury." 34 Pa. Code §127.406(b)(1).[5] The regulation also states that "[i]n medical only cases, when an insurer is paying for an injured worker's medical treatment" but has not admitted liability for a work-related injury, "the insurer may still seek review of the reasonableness or necessity of the treatment by filing a request for [utilization review]." 34 Pa. Code §127.405(a).

HN5[] In sum, where an employer challenges a provider's treatment as neither reasonable nor necessary for a work injury, it must seek utilization review pursuant to Section 301(f.1)(6) of the Act, 77 P.S. §531(6). Until the utilization review determination is issued, the employer may "suspend payment to the provider." Section 301(f.1)(5), 77 P.S. §531(5). Where a provider does not receive payment within 30 days (and payment has not been stayed by an employer's utilization review request), the provider may file a fee review petition pursuant to Section 301(f.1)(5) of the Act, 77 P.S. §531(5).

HN6[] A fee review proceeding is not the mechanism for establishing that a claimant has sustained a work-related injury or the scope of the work injury. As this Court has explained:

> the fee review process *presupposes* that liability has been established, either by voluntary acceptance by the employer or a determination by a WCJ. Neither the Act nor the **[**11]** medical cost containment regulations provide any authority for a fee review officer to decide the issue of liability in a fee review proceeding. The Department's regulations, at 34 Pa. Code §127.255(1), state that an application for fee review filed by a provider is premature and will be returned if "[t]he insurer denies liability for the alleged work injury." The issue for the fee review officer is the "amount and timelines[s] of the payment made by an insurer." 34 Pa. Code §127.251.

Nickel v. Workers' Compensation Appeal Board (Agway Agronomy), 959 A.2d 498, 503 (Pa. Cmwlth. 2008) (emphasis added). Accordingly, ***HN7***[] the medical cost containment regulation states that a fee review is premature in the following instances:

> (1) The insurer denies liability for the alleged work injury.
> (2) The insurer has filed a request for utilization review of the treatment under Subchapter C (relating to medical treatment review).
> (3) The 30-day period allowed for payment has not yet elapsed, as computed under §127.208 (relating to time for payment of medical bills).

34 Pa. Code §127.255.

---

[5] The cost containment regulation states as follows:

> (a) UROs [Utilization Review Organizations] shall decide only the reasonableness or necessity of the treatment under review.
>
> (b) UROs may not decide any of the following issues:
>
> (1) The causal relationship between the treatment under review and the employe's work-related injury.
>
> (2) Whether the employe is still disabled.
>
> (3) Whether "maximum medical improvement" has been obtained.
>
> (4) Whether **[**10]** the provider performed the treatment under review as a result of an unlawful self-referral.
>
> (5) The reasonableness of the fees charged by the provider.
>
> (6) The appropriateness of the diagnostic or procedural codes used by the provider for billing purposes.
>
> (7) Other issues which do not directly relate to the reasonableness or necessity of the treatment under review.

34 Pa. Code §127.406

A dispute about whether a claimant has a work injury, or the scope of that **[*619]** injury, must be litigated in accordance with the procedures of the Act for a claim petition proceeding. *See Inglis House v. Workmen's Compensation Appeal Board (Reedy)*, 535 Pa. 135, 634 A.2d 592, 595 (Pa. 1993) ("[I]n a claim proceeding, the employee bears the burden of establishing a right to compensation and of proving **[**12]** all necessary elements to support an award.").

HN8[⬆] In *Armour Pharmacy I*, 192 A.3d 304 (Pa. Cmwlth. 2018), a compound cream prescribed to the claimant had previously been determined to be a reasonable and necessary treatment of the claimant's accepted work injury. When the employer refused to reimburse the pharmacy for this compound cream, the Bureau's Medical Fee Review Section directed the employer to pay the repriced invoice with interest. While the employer's appeal was pending, the claimant and the employer entered into a C & R agreement in which the employer accepted liability for past medical expenses incurred, with the exception of the compound cream. The C & R agreement also stated that the claimant was excused from liability for the compound cream. The Hearing Office held that the C & R agreement extinguished the employer's liability for the compound cream and, thus, vacated the fee determination of the Medical Fee Review Section.

On appeal, this Court vacated the adjudication of the Hearing Office and remanded the matter for further proceedings. ***HN9***[⬆] We held that "[a] C & R [a]greement, to which a provider is not a party, cannot be used to deprive a provider of the review procedures and excuse the employer from paying the provider." **[**13]** *Armour Pharmacy I*, 192 A.3d at 312. "To hold otherwise would eviscerate Section 301(f.1)(5) and (6) of the Act and violate the due process of law guaranteed to providers." *Id.* Further, the C & R agreement obligated the employer to pay past medical expenses, and the utilization review had found the compound cream at issue to be reasonable and necessary for treatment of the claimant's work injury. In short, the C & R agreement made the employer liable for the prescription.

HN10[⬆] In *Armour Pharmacy II*, 206 A.3d 660, the employer refused to reimburse the pharmacy for the stated reason that the pharmacy was not a "health care provider" as defined by the Act[6] and, thus, not entitled to reimbursement. Explaining that the fee review procedure is designed to determine the amount or timeliness of payment for medical treatment, the Hearing Office concluded that whether a pharmacy is a health care "provider" under the Act was beyond the scope of a fee review proceeding. The Hearing Office dismissed the matter for lack of jurisdiction.

On appeal to this Court, the pharmacy argued it had been denied due process of law because the Act provided no forum for the pharmacy to litigate the question of whether the pharmacy was a health care provider within the meaning of the Act. We agreed that it violated due process to leave the pharmacy without a forum to litigate its provider status and held that the

---

[6] Section 109 of the Act defines a "health care provider" as follows:

> *[A]ny person, corporation, facility or institution licensed or otherwise authorized by the Commonwealth to provide health care services*, including, but not limited to, any physician, coordinated care organization, hospital, health care facility, dentist, nurse, **[**14]** optometrist, podiatrist, physical therapist, psychologist, chiropractor *or pharmacist* and an officer, employe or agent of such person acting in the course and scope of employment or agency related to health care services.

77 P.S. §29 (emphasis added).

threshold question of whether the **[*620]** pharmacy was a provider was a matter for the Hearing Office to determine.

With these principles in mind, we turn to the instant appeal.

Analysis

Pharmacy argues that Employer waived its right to challenge the compound cream as not related to the accepted work injury because it did not seek utilization review of Pharmacy's invoice. As such, Employer had the obligation to pay the invoice within 30 days of its receipt. *See* 34 Pa. Code §127.255 ***HN11***[⬆] (fee review of non-payment of provider invoice is premature only where the employer denies liability for the work injury; has requested utilization review; **[**15]** or 30 days has not yet elapsed). Pharmacy contends that because Employer lacked grounds for not paying the compound cream invoice in a timely manner, Pharmacy's fee review application was not premature.

Employer responds that only a WCJ can determine whether a provider's treatment relates to a work injury or to another, non-work-related problem. Here, the prescription instructed Claimant to apply the compound cream to the "affected area 2-4 times daily" but did not identify the body part. R.R. 13a. Employer notes that the cost containment regulation states that utilization review does not decide the "causal relationship between the treatment under review and the employe's work-related injury." 34 Pa. Code §127.406(b)(1). Employer further notes that the Hearing Office found that Employer believed the "topical solution is not related to the work injury." Adjudication, 6/7/2018, Finding of Fact No. 13, at 4; R.R. 108a.

In support of their respective positions, the parties both cite *Crozer Chester Medical Center v. Department of Labor and Industry, Bureau of Workers' Compensation Health Care Services Review Division*, 610 Pa. 459, 22 A.3d 189 (Pa. 2011). In that case, the medical center filed a petition for review addressed to this Court's original jurisdiction to compel the Department to hold a hearing on its fee petition. This Court dismissed Crozer's request for a writ of mandamus, **[**16]** and Crozer appealed. The Department argued that there were practical considerations for a "regulatory prohibition against litigating liability within the context of the fee review process." *Id.* at 193. The Supreme Court agreed. It concluded that because the employer disputed liability, the medical center did not state a claim in mandamus.[7] The Supreme Court observed that the employer may "question liability for a particular treatment" by filing a petition to modify the description of the work injury in the notice of compensation payable (NCP) or by seeking a utilization review of the "'reasonableness or necessity' of a treatment offered for an accepted work-related injury." *Id.* at 195.

Here, liability for Claimant's work injury has been established. As the Supreme Court observed in *Crozer*, to question liability for the compound cream treatment, Employer could have filed a modification petition to change the scope of the accepted work injury or sought utilization review of the treatment. Employer did neither.

Had Employer sought utilization review, its 30-day deadline to pay Pharmacy's invoice would have been stayed. ***HN12***[⬆] Claimant may be

[7] The Supreme Court was split. Justice Baer, joined by Justices Todd and McCaffery, would have permitted the petition for review to proceed and would have granted the writ of mandamus.

under treatment for an array of medical problems, only some of which relate **[**17]** to the work injury. It is for the Utilization Review Organization to sort this **[*621]** out.[8] If the compound cream was prescribed for a non-work-related injury of Claimant, *a fortiori* it is not reasonable or necessary for treatment of her accepted work injury. Employer's stated reason for denying Pharmacy's invoice was that the "diagnosis is inconsistent with the procedure." R.R. 11a. This is just another way of stating that the compound cream was not a reasonable or necessary "procedure" for treating Claimant's "diagnosis," *i.e.*, a shoulder sprain.

HN13[] An application for fee review is deemed premature in three circumstances: (1) where the insurer denies liability for the alleged work injury; (2) where the insurer has filed a request for utilization review; or (3) where the 30-day period insurer is allowed for payment of a provider's invoice has not yet elapsed. 34 Pa. Code §127.255. Here, the Hearing Office concluded that Pharmacy's fee review was premature because Employer denied that the compound cream was related to Claimant's accepted work injury. The Hearing Office erred because Employer's non-payment did not fit any of the exceptions to the rule that an employer must pay an invoice within 30 days. *See* 34 Pa. Code §127.255. Employer **[**18]** did not file a modification petition to revise Claimant's accepted work injury and did not seek utilization review. Employer expressly accepted liability for Claimant's work injury in the nature of a right shoulder strain both in the NTCP and in the C & R Agreement.9[1]

Employer contends that the compound cream was not related to the accepted work injury, *i.e.*, a shoulder sprain. It argues that its liability for this treatment must be established in a claim petition proceeding. We disagree. The work injury has been accepted, and the sole question is whether the compound cream was reasonable and necessary for treatment of the accepted work injury. This is an issue for utilization review.

We hold that Employer was obligated to seek utilization review upon receipt of Pharmacy's invoice. Had Employer sought utilization review, the filing of Pharmacy's fee review petition would have been premature. 34 Pa. Code §127.255. Further, Employer's liability to Pharmacy would have been "suspend[ed]" pursuant to Section 301(f.1)(5) of the Act, 77 P.S. §531(5). The Hearing Office erred in finding Pharmacy's fee review petition premature because Employer had accepted liability for Claimant's work injury and had not sought utilization review to challenge the **[**19]** compound cream as neither reasonable nor necessary for treatment of Claimant's work-related shoulder sprain.[10]

Conclusion

For all the above reasons, we vacate the

[8] Under the Bureau's regulation, the Utilization Review Organization (URO) does not decide an issue about the "causal relationship" between the treatment and the "employe's work injury." 34 Pa. Code §127.406(b)(1). On the other hand, the URO must decide the "reasonableness or necessity of the treatment." 34 Pa. Code §127.406(a). The regulation is ambiguous. The mandate to determine "reasonableness or necessity" of the treatment cannot be sidestepped. That the treatment may be reasonable for a non-work-related injury is beyond the scope of utilization review, which may be the purpose of 34 Pa. Code §127.406(b)(1).

[9] To be sure, Employer opposed Claimant's effort to expand the description of the work injury to include an acromioclavicular joint separation and a clavicular avulsion fracture.

[10] Because we find that Pharmacy's fee review petition was not premature, we need not consider Pharmacy's second issue, *i.e.*, whether the Hearing Office's dismissal of Employer's appeal of the fee determination violated Pharmacy's right to due process in accordance with *Armour Pharmacy II*.

determination of the Hearing Office that **[*622]** Employer's fee review petition was premature and remand to the Hearing Office for a decision on the merits of the fee review determination.

MARY HANNAH LEAVITT, President Judge

ORDER

AND NOW, this 16th day of January, 2020 the order of the Bureau of Workers' Compensation Fee Review Hearing Office, dated June 7, 2018, is hereby VACATED and this matter is REMANDED for further proceedings in accordance with the attached opinion.

Jurisdiction relinquished.

MARY HANNAH LEAVITT, President Judge
