

“THE PENNSYLVANIA WORKERS’ COMPENSATION ACT”

Act of 1915, P.L. 736, No. 338, as amended.

Title 77 of Purdon’s Statutes

AN ACT

Amending the act of June 2, 1915 (P.L.736, No.338), entitled, as reenacted and amended, “An act defining the liability of an employer to pay damages for injuries received by an employe in the course of employment; establishing an elective schedule of compensation; providing procedure for the determination of liability and compensation thereunder; and prescribing penalties,” further providing for definitions, for recovery, for liability for compensation, for financial responsibility, for compensation schedules and for wages; providing for reporting; further providing for notices, for examinations, for commutation of compensation, for exclusions, for the Workmen’s Compensation Appeal Board and for procedure; providing for informal conferences; further providing for processing claims, for commutation petitions, for modifications and reversals, for pleadings, for investigations, for evidence, for appeals, for regulations, for costs and attorney fees, for the Pennsylvania Workers’ Compensation Advisory Council and for insurance policies; providing for settlements and for collective bargaining; further providing for ratings organizations, for rating procedures and for shared liability; providing for employer association groups; further providing for safety committees, for penalties, for prosecutions and for collection of penalties; providing for limitation of actions; further providing for assessments; providing for workers’ compensation judges and for transfer of administrative functions; transferring provisions relating to the State Workmen’s Insurance Fund and broadening its permissible coverages; and making a repeal.

ARTICLE I

Interpretation and Definitions

- Sec 101 That this act shall be called and cited as the Workers’ Compensation Act, and shall apply to all injuries occurring within this Commonwealth, irrespective of the place where the contract of hiring was made, renewed, or extended, and extraterritorially as provided by section 305.2.
- Sec 102 Wherever in this act the singular is used, the plural shall be included; where the masculine gender is used, the feminine and neuter shall be included.
- Sec 103 The term “employer,” as used in this act, is declared to be synonymous with master, and to include natural persons, partnerships, joint-stock companies, corporations for profit, corporations not for profit, municipal corporations, the Commonwealth, and all governmental agencies created by it.
- Sec 104 The term “employe,” as used in this act is declared to be synonymous with servant, and includes—

All natural persons who perform services for another for a valuable consideration, exclusive of persons whose employment is casual in character and not in the regular course of the business of the employer, and exclusive of persons to whom articles or materials are given out to be made up, cleaned, washed, altered, ornamented, finished or repaired, or adapted for sale in the worker’s own home, or on other premises, not under the control or management of the employer. Except as hereinafter provided in clause (c) of section 302 and sections 305 and 321, every executive officer of a corporation elected or appointed in accordance with the charter and by-laws of the corporation, except elected officers of the Commonwealth or any of its political subdivisions, shall be an employe of the corporation. An executive officer of a for-profit corporation or an executive officer of a nonprofit corporation who serves voluntarily and without remuneration may, however, elect not to be an employe of the corporation for the purposes of this act. For purposes of this section, an executive officer of a for-profit corporation is an individual who has an ownership interest in the corporation, in the case of a Subchapter S corporation as defined by the act of March 4, 1971 (P.L. 6, No. 2), known as the “Tax Reform Code of 1971,” or an ownership interest in the corporation of at least five per centum, in the case of a Subchapter C corporation as defined by the Tax Reform Code of 1971.

In addition to those persons included within the definition of the word “employee” as defined in section 104 of the act of June 2, 1915 (P.L. 736), known as “The Pennsylvania Workmen’s Compensation Act”, reenacted and amended June 21, 1939 (P.L. 520), and amended February 28, 1956 (P.L. 1120), there shall be included all auxiliary police of the various cities, boroughs, incorporated towns and townships, who shall be “employees” of such cities, boroughs, incorporated towns and townships for all the purposes of the act, and shall be entitled to receive compensation in case of injuries received while actually engaged as policemen or while going to or returning from their place of duty or while participating in instruction or while answering any emergency call for any purpose or while performing any other duty authorized by the city, borough, incorporated town or township.

The city, borough, incorporated town or township as employer shall, in all cases, be deemed to have knowledge of all other employment of all auxiliary police, including self employment, and earnings in such employment shall be included in computing average weekly wages. In all cases where an injury compensable under the provisions of this act is received by an auxiliary policeman who is, in whole or in part, a self employer and loss of earnings results therefrom, such earnings shall for the purposes of this act be regarded as wages. The average weekly wage as so regarded shall be that most favorable to the employe computed by dividing by thirteen the total earnings of the employe in the first, second, third or fourth period of thirteen consecutive calendar weeks in the fifty-two weeks immediately preceding the accident. In all cases where an injury compensable under the provisions of this act is received by a member of the auxiliary police who is self-employed or unemployed, payments shall be made of not less than twenty-two dollars and fifty cents (\$22.50) per week for total disability and not less than twelve dollars and fifty cents (\$12.50) for partial disability.

In addition to those persons included within the definition of the word “employee” as defined in section 104, act of June 2, 1915 (P.L. 736), known as “The Pennsylvania Workmen’s Compensation Act”, reenacted and amended June 21, 1939 (P.L. 520), and amended February 28, 1956 (P.L. 1120), there shall be included all special school police in municipalities and townships, who shall be and are hereby declared to be “employees” of the appointing municipality or township for all the purposes of said act, and shall be entitled to receive compensation in case of injuries received while actually engaged as policemen or while participating in instruction or while answering any emergency call for any purpose or while performing any other duty authorized by the municipality or township.

The municipality or township as employer shall, in all cases, be deemed to have knowledge of all other employment of all members of its special school police, including self-employment, and shall be liable for compensation on account of all wages and earnings resulting therefrom. In all cases where an injury compensable under the provisions of this act is received by a member of the special school police who is, in whole or in part, a self-employer and loss of earnings results therefrom, such earnings shall, for the purposes of this act, be regarded as wages. The average weekly wage as so regarded shall be that most favorable to the employe, computed by dividing by thirteen the total earnings of the employe in the first, second, third or fourth period of thirteen consecutive calendar weeks in the fifty-two weeks immediately preceding the accident. In all cases where an injury compensable under the provisions of this act is received by a member of the special school police of a municipality or township, who is self-employed or unemployed, payments shall be made of not less than twenty-two dollars and fifty cents (\$22.50) per week for total disability and not less than twelve dollars and fifty cents (\$12.50) for partial disability.

Sec 105 The term “contractor,” as used in article two, section two hundred and three, and article three, section three hundred and two (b), shall not include a contractor engaged in an independent business, other than that of supplying laborers or assistants, in which he serves persons other than the employer in whose service the injury occurs, but shall include a sub-contractor to whom a principal contractor has sublet any part of the work which such principal contractor has undertaken.

Sec 105.1 The term “the Statewide average weekly wage,” as used in this act, means that amount which shall be determined annually by the department for each calendar year on the basis of employment covered by the Pennsylvania Unemployment Compensation Law for the twelve-month period ending June 30 preceding the calendar year.

- Sec 105.2 The terms “the maximum weekly compensation payable” and “the maximum compensation payable per week,” as used in this act, mean sixty-six and two-thirds per centum of “the Statewide average weekly wage” as defined in section 105.1. Effective July 1, 1975, the terms “the maximum weekly compensation payable” and “the maximum compensation payable per week” as used in this act for injuries or death after the effective date of this amendatory act shall mean the Statewide average weekly wage as defined in section 105.
- Sec 105.3 The term “construction design professional,” as used in this act, means a professional engineer or land surveyor licensed by the State Registration Board for Professional Engineers, Land Surveyors and Geologists under the act of May 23, 1945 (P.L. 913, No. 367), known as the “Engineer, Land Surveyor and Geologist Registration Law,” a landscape architect who is licensed by the State Board of Landscape Architects under the act of January 24, 1966 (1965 P.L. 1527, No. 535), known as the “Landscape Architects’ Registration Law,” an architect who is licensed by the Architects Licensure Board under the act of December 14, 1982 (P.L. 1227, No. 281), known as the “Architects Licensure Law,” or any corporation or association, including professional corporations, organized or registered under the act of December 21, 1988 (P.L. 1444, No. 177), known as the “General Association Act of 1988,” practicing engineering, architecture, landscape architecture or surveying in this Commonwealth.
- Sec 105.4 The term “hazardous occupational noise,” as used in this act, means noise levels exceeding permissible noise exposures as defined in Table G-16 of OSHA Occupational Noise Exposure Standards, 29 CFR 1910.95 (relating to occupational noise exposure) (July 1, 1994).
- Sec 105.5 The term “Impairment Guides,” as used in this act, means the American Medical Association’s Guides to the Evaluation of Permanent Impairment, Fourth Edition (June 1993).
- Sec 105.6 The term “long-term exposure,” as used in this act, means exposure to noise exceeding the permissible daily exposure for at least three days each week for forty weeks of one year.
- Sec 106 The exercise and performance of the powers and duties of a local or other public authority shall, for the purposes of this act, be treated as the trade or business of the authority.
- Sec 107 The term “Department,” when used in this act, shall mean the Department of Labor and Industry of this Commonwealth.
- The term “Board,” when used in this act, shall mean The Workers’ Compensation Appeal Board of this Commonwealth.
- Sec 108 The term “occupational disease,” as used in this act, shall mean only the following diseases.
- (a) Poisoning by arsenic, lead, mercury, manganese, or beryllium, their preparations or compounds, in any occupation involving direct contact with, handling thereof, or exposure thereto.
 - (b) Poisoning by phosphorus, its preparations or compounds, in any occupation involving direct contact with, handling thereof, or exposure thereto.
 - (c) Poisoning by methanol, carbon bisulfide, carbon monoxide, hydrocarbon distillates (naphthas and others) or halogenated hydrocarbons, toluene diisocyanate (T.D.1.) or any preparations containing these chemicals or any of them, in any occupation involving direct contact with, handling thereof, or exposure thereto.
 - (d) Poisoning by benzol, or by nitro, amido, or amino derivatives of benzol (dinitro-benzol, aniline, and others), or their preparations or compounds, in any occupation involving direct contact with, handling thereof, or exposure thereto.
 - (e) Caisson disease (compressed air illness) resulting from engaging in any occupation carried on in compressed air.

- (f) Radium poisoning or disability, due to radioactive properties of substances or to Roentgen-ray (X-rays) in any occupation involving direct contact with, handling thereof, or exposure thereto.
- (g) Poisoning by, or ulceration from chronic acid, or bichromate of ammonium, bichromate of potassium, or bichromate of sodium, or their preparations, in any occupation involving direct contact with, handling thereof, or exposure thereto.
- (h) Epitheliomatous cancer or ulceration due to tar, pitch, bitumen, mineral oil, or paraffin, or any compound, product or residue of any of those substances, in any occupation involving direct contact with, handling thereof, or exposure thereto.
- (i) Infection or inflammation of the skin due to oils, cutting compounds, lubricants, dust, liquids, fumes, gasses, or vapor, in any occupation involving direct contact with, handling thereof, or exposure thereto.
- (j) Anthrax occurring in any occupation involving the handling of, or exposure to wool, hair, bristles, hides, or skins, or bodies of animals either alive or dead.
- (k) Silicosis in any occupation involving direct contact with, handling of, or exposure to the dust of silicon dioxide.
- (l) Asbestosis and cancer resulting from direct contact with, handling of, or exposure to the dust of asbestos in any occupation involving such contact, handling or exposure.
- (m) Tuberculosis, serum hepatitis or infectious hepatitis in the occupations of blood processors, fractionators, nursing, or auxiliary services involving exposure to such diseases.
- (n) All other diseases (1) to which the claimant is exposed by reason of his employment, and (2) which are causally related to the industry or occupation, and (3) the incidence of which is substantially greater in that industry or occupation than in the general population. For the purposes of this clause, partial loss of hearing in one or both ears due to noise; and the diseases silicosis, anthracosilicosis and coal workers' pneumoconiosis resulting from employment in and around a coal mine, shall not be considered occupational diseases.
- (o) Diseases of the heart and lungs, resulting in either temporary or permanent total or partial disability or death, after four years or more of service in fire fighting for the benefit or safety of the public, caused by extreme over-exertion in times of stress or danger or by exposure to heat, smoke, fumes or gasses, arising directly out of the employment of any such firemen.
- (p) Byssinosis in any occupation involving direct contact with, handling of, or exposure to cotton dust, cotton materials, or cotton fibers.
- (q) Coal worker's pneumoconiosis, anthracosilicosis and silicosis (also known as miner's asthma or black lung) in any occupation involving direct contact with, handling of, or exposure to the dust of anthracite or bituminous coal.

Sec 109

In addition to the definitions set forth in this article, the following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

“Adjudication” shall have the meaning given in 2 Pa.C.S. §101 (relating to definitions).

“Bill” means a statement or invoice for payment of services under subsection (f.1) of section 306 which identifies the claimant, the date of injury, the payment codes referred to in subsection (f.1) of section 306 and a description of the services provided on or in standard form prescribed by the Department of Labor and Industry.

“Burn facility” means a facility which meets the service standards of the American Burn Association.

“Commissioner” means the Insurance Commissioner of the Commonwealth.

“Coordinated care organization” or “CCO” means an organization licensed in Pennsylvania and certified by the Secretary of Labor and Industry on the basis of established criteria possessing the capacity to provide medical services to an injured worker.

“DRG” means diagnosis-related groups.

“HCFA” means the Health Care Financing Administration.

“Health care provider” means any 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.

“Health maintenance organization” means an entity defined in and subject to the act of December 29, 1972 (P.L. 1701, No. 364), known as the “Health Maintenance Organization Act.”

“Hospital plan corporation” means an entity defined in and subject to 40 Pa. C.S. Ch. 61 (relating to hospital plan corporations).

“Insurance Company Law of 1921” means the act of May 17, 1921 (P.L. 682, No. 284), known as “The Insurance Company Law of 1921.”

“Insurer” means an entity subject to the act of May 17, 1921 (P.L. 682, No. 284), known as “The Insurance Company Law of 1921,” including the State Workmen’s Insurance Fund, with which an employer has insured liability under this act pursuant to section 305 or a self-insured employer or fund exempted by the Department of Labor and Industry pursuant to section 305.

“Intermediary” means an organization with a contractual relationship with the Health Care Financing Administration to process Medicare Part A or Part B claims.

“Life-threatening injury” shall be as defined by the American College of Surgeons’ triage guidelines regarding use of trauma centers for the region where the services are provided.

“Occupational Disease Act” means the act of June 21, 1939 (P.L. 566, No. 284), known as “The Pennsylvania Occupational Disease Act.”

“Pass-through costs” means Medicare-reimbursed costs to a hospital that “pass through” the prospective payment system and are not included in the diagnosis-related group payments. The term includes medical education, capital expenditures, insurance and interest expense on fixed assets.

“Peer review,” for the purpose of undertaking reviews and reports pursuant to section 420, means review by:

- (1) an impartial physician or other health care provider selected by the Secretary of Labor and Industry upon recommendation of the deans of the medical colleges located in this Commonwealth;
- (2) a panel of such professionals and providers selected by the Secretary of Labor and Industry upon recommendation of the deans of the medical colleges located in this Commonwealth or recommendation of professional associations representing such professionals and providers; or

(3) a Peer Review Organization approved by the commissioner and selected by the Secretary of Labor and Industry.

“Professional health service corporation” means an entity defined in and subject to 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

“Provider” means a health care provider.

“Referee” means a workers’ compensation judge, as designated under section 401.

“Secretary” means the Secretary of Labor and Industry of the Commonwealth.

“Trauma center” means a facility accredited by the Pennsylvania Trauma Systems Foundation under the act of July 3, 1985 (P.L. 164, No. 45), known as the “Emergency Medical Services Act.”

“Urgent injury” shall be 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” means 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.

“Utilization review organizations” shall be those organizations consisting of an impartial physician, surgeon or other health care provider or a panel of such professionals and providers as authorized by the Secretary of Labor and Industry and published as a list in the form of a notice in the Pennsylvania Bulletin for the purpose of reviewing the reasonableness and necessity of treatment by a health care provider pursuant to section 306(f.1)(6).

ARTICLE II
Damages by Action at Law

- Sec 201 That in any action brought to recover damages for personal injury to an employe in the course of his employment, or for death resulting from such injury, it shall not be a defense—
- (a) That the injury was caused in whole or in part by the negligence of a fellow employe; or
 - (b) That the employe has assumed the risk of the injury; or
 - (c) That the injury was caused in any degree by the negligence of such employe, unless it can be established that the injury was caused by such employe's intoxication or by his reckless indifference to danger. The burden of proving such intoxication or reckless indifference to danger shall be upon the defendant, and the question shall be one of fact to be determined by the jury.
- Sec 202 The employer shall be liable for the negligence of all employes, while acting within the scope of their employment, including engineers, chauffeurs, miners, mine-foremen, fire-bosses, mine superintendents, plumbers, officers of vessels, and all other employes licensed by the Commonwealth or other governmental authority, if the employer be allowed by law the right of free selection of such employes from the class of persons thus licensed; and such employes shall be the agents and representatives of their employers and their employers shall be responsible for the acts and neglects of such employes, as in the case of other agents and employes of their employers; and, notwithstanding the employment of such employes, the property in and about which they are employed, and the use and operation thereof, shall at all times be under the supervision, management and control of their employers.
- Sec 203 An employer who permits the entry upon premises occupied by him or under his control of a laborer or an assistant hired by an employer or contractor, for the performance upon such premises of a part of the employer's regular business entrusted to such employe or contractor, shall be liable to such laborer or assistant in the same manner and to the same extent as to his own employe.
- Sec 204
- (a) No agreement, composition, or release of damages made before the date of any injury shall be valid or shall bar a claim for damages resulting therefrom; and any such agreement is declared to be against the public policy of this Commonwealth. The receipt of benefits from any association, society, or fund shall not bar the recovery of damages by action at law, nor the recovery of compensation under article three hereof; and any release executed in consideration of such benefits shall be void: Provided, however, That if the employe receives unemployment compensation benefits, such amount or amounts so received shall be credited as against the amount of the award made under the provisions of sections 108 and 306, except for benefits payable under section 306(c) or 307. Fifty per centum of the benefits commonly characterized as "old age" benefits under the Social Security Act (49 Stat. 620, 42 U.S.C. 301 et seq.) shall also be credited against the amount of the payments made under sections 108 and 306, except for benefits payable under section 306(c): Provided, however, That the Social Security offset shall not apply if old age Social Security benefits were received prior to the compensable injury. The severance benefits paid by the employer directly liable for the payment of compensation and the benefits from a pension plan to the extent funded by the employer directly liable for the payment of compensation which are received by an employe shall also be credited against the amount of the award made under sections 108 and 306, except for benefits payable under section 306(c). The employe shall provide the insurer with proper authorization to secure the amount which the employe is receiving under the Social Security Act.
 - (b) For the exclusive purpose of determining eligibility for compensation under the act of December 5, 1936 (2nd Sp. Sess., 1937 P.L. 2897, No.1), known as the "Unemployment Compensation Law," any employe who does not meet the monetary and credit week requirements under section 401(a) of that act due to a work-related injury compensable under this act may elect to have his base year consist of the four complete calendar quarters immediately preceding the date of the work-related injury.

- (c) The employe is required to report regularly to the insurer the receipt of unemployment compensation benefits, wages received in employment or self-employment, benefits commonly characterized as "old age" benefits under the Social Security Act, severance benefits and pension benefits, which post-date the compensable injury under this act, subject to the fraud provisions of Article XI.
- (d) The department shall prepare the forms necessary for the enforcement of this section and issue rules and regulations as appropriate.

Sec 205 If disability or death is compensable under this act, a person shall not be liable to anyone at common law or otherwise on account of such disability or death for any act or omission occurring while such person was in the same employ as the person disabled or killed, except for intentional wrong.

ARTICLE III
Liability and Compensation

- Sec 301 (a) Every employer shall be liable for compensation for personal injury to, or for the death of each employe, by an injury in the course of his employment, and such compensation shall be paid in all cases by the employer, without regard to negligence, according to the schedule contained in sections three hundred and six and three hundred and seven of this article: Provided, That no compensation shall be paid when the injury or death is intentionally self inflicted, or is caused by the employe's violation of law, including, but not limited to, the illegal use of drugs, but the burden of proof of such fact shall be upon the employer, and no compensation shall be paid if, during hostile attacks on the United States, injury or death of employes results solely from military activities of the armed forces of the United States or from military activities or enemy sabotage of a foreign power. In cases where the injury or death is caused by intoxication, no compensation shall be paid if the injury or death would not have occurred but for the employe's intoxication, but the burden of proof of such fact shall be upon the employer.
- (b) The right to receive compensation under this act shall not be affected by the fact that a minor is employed or is permitted to be employed in violation of the laws of this Commonwealth relating to the employment of minors, or that he obtained his employment by misrepresenting his age.
- (c) (1) The terms "injury" and "personal injury," as used in this act, shall be construed to mean an injury to an employe, regardless of his previous physical condition, arising in the course of his employment and related thereto, and such disease or infection as naturally results from the injury or is aggravated, reactivated or accelerated by the injury; and wherever death is mentioned as a cause for compensation under this act, it shall mean only death resulting from such injury and its resultant effects, and occurring within three hundred weeks after the injury. The term "injury arising in the course of his employment," as used in this article, shall not include an injury caused by an act of a third person intended to injure the employe because of reasons personal to him, and not directed against him as an employe or because of his employment; nor shall it include injuries sustained while the employe is operating a motor vehicle provided by the employer if the employe is not otherwise in the course of employment at the time of injury; but shall include all other injuries sustained while the employe is actually engaged in the furtherance of the business or affairs of the employer, whether upon the employer's premises or elsewhere, and shall include all injuries caused by the condition of the premises or by the operation of the employer's business or affairs thereon, sustained by the employe, who, though not so engaged, is injured upon the premises occupied by or under the control of the employer, or upon which the employer's business or affairs are being carried on, the employe's presence thereon being required by the nature of his employment.
- (2) The terms "injury," "personal injury," and "injury arising in the course of his employment," as used in this act, shall include, unless the context clearly requires otherwise, occupational disease as defined in section 108 of this act: Provided, That whenever occupational disease is the basis for compensation, for disability or death under this act, it shall apply only to disability or death resulting from such disease and occurring within three hundred weeks after the last date of employment in an occupation or industry to which he was exposed to hazards of such disease: And provided further, That if the employe's compensable disability has occurred within such period, his subsequent death as a result of the disease shall likewise be compensable. The provisions of this paragraph (2) shall apply only with respect to the disability or death of an employe which results in whole or in part from the employe's exposure to the hazard of occupational disease after June 30, 1973 in employment covered by The Pennsylvania Workmen's Compensation Act. The employer liable for compensation provided by section 305.1 or section 108, subsections (k), (1), (m), (o), (p) or (q), shall be the employer in whose employment the employe was last exposed for a period of not less than one year to the hazard of the occupational disease claimed. In the event the employe did not

work in an exposure at least one year for any employer during the three hundred week period prior to disability or death, the employer liable for the compensation shall be that employer giving the longest period of employment in which the employe was exposed to the hazards of the disease claimed.

- (d) Compensation for silicosis, anthraco-silicosis, coal worker's pneumoconiosis or asbestosis, shall be paid only when it is shown that the employe has had an aggregate employment of at least two years in the Commonwealth of Pennsylvania, during a period of ten years next preceding the date of disability, in an occupation having a silica, coal or asbestos hazard.
- (e) If it is shown that the employe, at or immediately before the date of disability, was employed in any occupation or industry in which the occupational disease is a hazard, it shall be presumed that the employe's occupational disease arose out of and in the course of his employment, but this presumption shall not be conclusive.

Sec 302

- (a) A contractor who subcontracts all or any part of a contract and his insurer shall be liable for the payment of compensation to the employes of the subcontractor unless the subcontractor primarily liable for the payment of such compensation has secured its payment as provided for in this act. Any contractor or his insurer who shall become liable hereunder for such compensation may recover the amount thereof paid and any necessary expenses from the subcontractor primarily liable therefor.

For purposes of this subsection, a person who contracts with another (1) to have work performed consisting of (i) the removal, excavation or drilling of soil, rock or minerals, or (ii) the cutting or removal of timber from lands, or (2) to have work performed of a kind which is a regular or recurrent part of the business, occupation, profession or trade of such person shall be deemed a contractor, and such other person a subcontractor. This subsection shall not apply, however, to an owner or lessee of land principally used for agriculture who is not a covered employer under this act and who contracts for the removal of timber from such land.

- (b) Any employer who permits the entry upon premises occupied by him or under his control of a laborer or an assistant hired by an employe or contractor, for the performance upon such premises of a part of such employer's regular business entrusted to that employe or contractor, shall be liable for the payment of compensation to such laborer or assistant unless such hiring employe or contractor, if primarily liable for the payment of such compensation, has secured the payment thereof as provided for in this act. Any employer or his insurer who shall become liable hereunder for such compensation may recover the amount thereof paid and any necessary expenses from another person if the latter is primarily liable therefor.

For purposes of this subsection (b), the term "contractor" shall have the meaning ascribed in section 105 of this act.

- (c) Any employer employing persons in agricultural labor shall be required to provide workmen's compensation coverage for such employes according to the provisions of this act, if such employer is otherwise covered by the provisions of this act or if during the calendar year such employer pays wages to one employe for agricultural labor totaling one thousand two hundred dollars (\$1,200) or more or furnishes employment to one employe in agricultural labor on thirty or more days in any of which events the employer shall be required to provide coverage for all employes. For purposes of this clause, a spouse or a child of the employer under eighteen years of age shall not be deemed an employe unless the services of such spouse or child are engaged by the employer under an express written contract of hire which is filed with the department.
- (d) A contractor shall not subcontract all or any part of a contract unless the subcontractor has presented proof of insurance under this act.

- (e)
 - (1) Prior to issuing a building permit to a contractor, a municipality shall require the contractor to present proof of workers' compensation insurance or an affidavit that the contractor does not employ other individuals and is not required to carry workers' compensation insurance.
 - (2) Every building permit issued by a municipality to a contractor shall clearly set forth the name and workers' compensation policy and the contractor's Federal or State Employer Identification Number. This information shall be in addition to any information required by municipal ordinance. If the building permit is issued to an applicant which affirms it is not obligated to maintain workers' compensation insurance under this act, the permit shall clearly set forth the contractor's Federal or State Employer Identification Number and the substance of the affirmation and that the applicant is not permitted to employ any individual to perform work pursuant to the building permit.
 - (3) Every municipality issuing a building permit shall be named as a workers' compensation policy certificate holder of a contractor-issued building permit. This certificate shall be filed with the municipality's copy of the building permit. An insurer issuing a policy which names a municipality as a workers' compensation policy certificate holder pursuant to this section shall be required to notify that municipality of the expiration or cancellation of any such policy of insurance or policy certificate within three working days of such cancellation or expiration.
 - (4) A municipality shall issue a stop-work order to a contractor who is performing work pursuant to a building permit, upon receiving actual notice that the contractor's workers' compensation insurance or State-approved self-insured status has been cancelled. Also, if the municipality receives actual notice that a permittee, having filed an affidavit of exemption from workers' compensation insurance, has hired persons to perform work pursuant to a building permit and does not maintain required workers' compensation insurance, the municipality shall issue a stop-work order. This order shall remain in effect until proper workers' compensation coverage is obtained for all work performed pursuant to the building permit.
- (f)
 - (1) Where a contractor is performing work for a public body or political subdivision, all contractors and subcontractors shall provide proof of workers' compensation insurance to the public body or political subdivision effective for the duration of the work.
 - (2) The public body or political subdivision shall issue a stop-work order to any contractor who is performing work for that public body or political subdivision upon receiving notice that any public contractor's workers' compensation insurance, or State-approved self-insurance status, has expired or has been cancelled. If the public body or political subdivision receives actual notice that a contractor, having filed an affidavit of exemption from workers' compensation insurance, has hired persons to perform work for a public body or political subdivision and does not maintain the required workers' compensation insurance or self-insurance, the public body or political subdivision shall issue a stop work order, which order shall remain in effect until proper workers' compensation coverage is obtained for all work performed pursuant to the contract of work for the public body or political subdivision.
- (g) Should such policy of workers' compensation insurance be cancelled or expire during the duration of the work or should the workers' compensation self-insurance status change during the said period, the contractor shall immediately notify, in writing, the municipality, public body or political subdivision of such cancellation, expiration or change in status.
- (h) Nothing in this act shall be the basis of any liability on part of the municipality.
- (i) For purposes of subsections (d), (e) and (f), "proof of insurance" shall include a certificate of insurance or self-insurance, demonstrating current coverage and compliance with the require-

ments of this act, the Occupational Disease Act and the Longshore and Harbor Workers' Compensation Act (44 Stat. 1424, 33 U.S.C. § 901 et seq.), its amendments and supplements, where applicable.

- (j) For purposes of subsections (d), (e) and (f), "proof of insurance" shall not be required when the employer has been exempted pursuant to section 304.2.

Sec 303 (a) The liability of an employer under this act shall be exclusive and in place of any and all other liability to such employes, his legal representative, husband or wife, parents, dependents, next of kin or anyone otherwise entitled to damages in any action at law or otherwise on account of any injury or death as defined in section 301(c)(1) and (2) or occupational disease as defined in section 108.

- (b) In the event injury or death to an employe is caused by a third party, then such employe, his legal representative, husband or wife, parents, dependents, next of kin, and anyone otherwise entitled to receive damages by reason thereof, may bring their action at law against such third party, but the employer, his insurance carrier, their servants and agents, employes, representatives acting on their behalf or at their request shall not be liable to a third party for damages, contribution, or indemnity in any action at law, or otherwise, unless liability for such damages, contributions or indemnity shall be expressly provided for in written contract entered into by the party alleged to be liable prior to the date of the occurrence which gave rise to the action.

Sec 304 Repealed.

Sec 304.1 Repealed.

Sec 304.2 (a) An employer may file an application with the Department of Labor and Industry to be excepted from the provisions of this act in respect to certain employes. The application shall include a written waiver by the employe of all benefits under the act and an affidavit by the employe that he is a member of a recognized religious sect or division thereof and is an adherent of established tenets or teachings of such sect or division by reason of which he is conscientiously opposed to acceptance of the benefits of any public or private insurance which makes payments in the event of death, disability, old age or retirement or makes payments toward the cost of, or provides services for medical bills (including the benefits of any insurance system established by the Federal Social Security Act 42 U.S.C. 301 et seq.).

- (b) The waiver and affidavit required by subsection (a) shall be made upon a form to be provided by the Department of Labor and Industry.
- (c) Such application shall be granted if the Department of Labor and Industry shall find that (i) the employe is a member of a sect or division having the established tenets or teachings referred to in subsection (a); (ii) it is the practice, and has been for a substantial number of years, for members of such sect or division thereof to make provision for their dependent members which in its judgment is reasonable in view of their general level of living. Receipt of a form required by subsection (b) shall be considered prima facie proof that this subsection has been complied with.
- (d) When an employe is a minor, the waiver and affidavit required by subsection (a) may be made by guardian of the minor.
- (e) An exception granted in regard to a specific employe shall be valid for all future years unless such employe or sect ceases to meet the requirements of subsection (a).

Sec 305 (a) (1) Every employer liable under this act to pay compensation shall insure the payment of compensation in the State Workmen's Insurance Fund, or in any insurance company, or mutual association or company, authorized to insure such liability in this Commonwealth, unless

such employer shall be exempted by the department from such insurance. Such insurer shall assume the employer's liability hereunder and shall be entitled to all of the employer's immunities and protection hereunder except, that whenever any employer shall have purchased insurance to provide benefits under this act to persons engaged in domestic service, neither the employer nor the insurer may invoke the provisions of section 321 as a defense. An employer desiring to be exempt from insuring the whole or any part of his liability for compensation shall make application to the department, showing his financial ability to pay such compensation, whereupon the department, if satisfied of the applicant's financial ability, shall, upon the payment of a fee of five hundred dollars (\$500), issue to the applicant a permit authorizing such exemption.

- (2) In securing the payment of benefits, the department shall require an employer wishing to self-insure its liability and a group of employers approved to pool their liabilities under Article VIII to establish sufficient security by posting a bond or other security, including letters of credit drawn on commercial banks with a Thomson Bank Watch rating of B/C or better or a Thomson Bank Watch score of 2.5 or better for the bank or its holding company or with a CD rating of BBB or better by Standard and Poor's. This paragraph shall not apply to the Commonwealth or its political subdivisions.
 - (3) The department shall establish a period of twelve (12) calendar months, to begin and end at such times as the department shall prescribe, which shall be known as the annual exemption period. Unless previously revoked, all permits issued under this section shall expire and terminate on the last day of the annual exemption period for which they were issued. Permits issued under this act shall be renewed upon the filing of an application, and the payment of a renewal fee of one hundred dollars (\$100.00). The department may, from time to time, require further statements of the financial ability of such employer, and, if at any time such employer appear no longer able to pay compensation, shall revoke its permit granting exemption, in which case the employer shall immediately subscribe to the State Workmen's Insurance Fund, or insure his liability in any insurance company or mutual association or company, as aforesaid.
- (b) Any employer who fails to comply with the provisions of this section for every such failure, shall, upon conviction in the court of common pleas, be guilty of a misdemeanor of the third degree. If the failure to comply with this section is found by the court to be intentional, the employer shall be guilty of a felony of the third degree. Every day's violation shall constitute a separate offense. A judge of the court of common pleas may, in addition to imposing fines and imprisonment, include restitution in his order: Provided, That there is an injured employe who has obtained an award of compensation. The amount of restitution shall be limited to that specified in the award of compensation. It shall be the duty of the department to enforce the provisions of this section; and it shall investigate all violations that are brought to its notice and shall institute prosecutions for violations thereof. All fines recovered under the provisions of this section shall be paid to the department, and by it paid into the State Treasury and appropriated to the Office of Attorney General if the prosecutor is the Attorney General and paid to the operating fund of the county in which the district attorney is elected if the prosecutor is a district attorney.
 - (c) In any proceeding against an employer under this section, a certificate of non-insurance issued by the official Workmen's Compensation Rating and Inspection Bureau and a certificate of the department showing that the defendant has not been exempted from obtaining insurance under this section, shall be prima facie evidence of the facts therein stated.
 - (d) When any employer fails to secure the payment of compensation under this act as provided in sections 305 and 305.2, the injured employe or his dependents may proceed either under this act or in a suit for damages at law as provided by article II.
 - (e) Every employer shall post a notice at its primary place of business and at its sites of employment

in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employees or for the administration of first aid, containing:

- (1) Either the name of the employer's carrier and the address and telephone number of such carrier or insurer or, if the employer is self-insured, the name, address and telephone number of the person to whom claims or requests for information are to be addressed.
- (2) The following statement: "Remember, it is important to tell your employer about your injury." The notice shall be posted in prominent and easily accessible places at the site of employment, including such places as are used for treatment and first aid of injured employees. Such a listing shall contain the information as specified in this section, typed or printed on eight and one-half inch by eleven inch or eight and one-half inch by thirteen inch paper in standard size type or larger.

Sec 305.1 Any compensation payable under this act for silicosis, anthraco-silicosis or coal worker's pneumoconiosis as defined in section 108(q) for disability occurring on or after July 1, 1973 or for death resulting therefrom shall be paid as follows: if the disability begins between July 1, 1973 and June 30, 1974, inclusive, the employer shall pay twenty-five per centum and the Commonwealth seventy-five per centum; if the disability begins between July 1, 1974, and June 30, 1975, inclusive, the employer shall pay fifty per centum and the Commonwealth fifty per centum; if the disability begins between July 1, 1975 and June 30, 1976, inclusive, the employer shall pay seventy-five per centum and the Commonwealth twenty-five per centum; and if the disability begins on or after July 1, 1976, all compensation shall be payable by the employer. The procedures for payment of compensation in such cases shall be as prescribed in the rules and regulations of the department.

Sec 305.2 (a) If an employe, while working outside the territorial limits of this State, suffers an injury on account of which he, or in the event of his death, his dependents, would have been entitled to the benefits provided by this act had such injury occurred within this State, such employe, or in the event of his death resulting from such injury, his dependents, shall be entitled to the benefits provided by this act, provided that at the time of such injury:

- (1) His employment is principally localized in this State, or
- (2) He is working under a contract of hire made in this State in employment not principally localized in any state, or
- (3) He is working under a contract of hire made in this State in employment principally localized in another state whose workmen's compensation law is not applicable to his employer, or
- (4) He is working under a contract of hire made in this State for employment outside the United States and Canada.

(b) The payment or award of benefits under the workmen's compensation law of another state, territory, province or foreign nation to an employe or his dependents otherwise entitled on account of such injury or death to the benefits of this act shall not be a bar to a claim for benefits under this act; provided that claim under this act is filed within three years after such injury or death. If compensation is paid or awarded under this act:

- (1) The medical and related benefits furnished or paid for by the employer under such other workmen's compensation law on account of such injury or death shall be credited against the medical and related benefits to which the employe would have been entitled under this act had claim been made solely under this act.
- (2) The total amount of all income benefits paid or awarded the employe under such other

workmen's compensation law shall be credited against the total amount of income benefits which would have been due the employe under this act, had claim been made solely under this act.

- (3) The total amount of death benefits paid or awarded under such other workmen's compensation law shall be credited against the total amount of death benefits due under this act.

Nothing in this act shall be construed to mean that coverage under this act excludes coverage under another law or that an employe's election to claim compensation under this act is exclusive of coverage under another state act or is binding on the employe or dependent, except, perhaps to the extent of an agreement between the employe and the employer or where employment is localized to the extent that an employe's duties require him to travel regularly in this State and another state or states.

- (c) If an employe is entitled to the benefits of this act by reason of an injury sustained in this State in employment by an employer who is domiciled in another state and who has not secured the payment of compensation as required by this act, the employer or his carrier may file with the director a certificate, issued by the commission or agency of such other state having jurisdiction over workmen's compensation claims, certifying that such employer has secured the payment of compensation under the workmen's compensation law of such other state and that with respect to said injury such employe is entitled to the benefits provided under such law.

In such event:

- (1) The filing of such certificate shall constitute an appointment by such employer or his carrier of the Secretary of Labor and Industry as his agent for acceptance of the service of process in any proceeding brought by such employe or his dependents to enforce his or their rights under this act on account of such injury;
- (2) The secretary shall send to such employer or carrier, by registered or certified mail to the address shown on such certificate, a true copy of any notice of claim or other process served on the secretary by the employe or his dependents in any proceeding brought to enforce his or their rights under this act;
- (3)
 - (i) If such employer is a qualified self-insurer under the workmen's compensation law of such other state, such employer shall, upon submission of evidence, satisfactory to the director, of his ability to meet his liability to such employe under this act, be deemed to be a qualified self-insurer under this act;
 - (ii) If such employer's liability under the workmen's compensation law of such other state is insured, such employer's carrier, as to such employe or his dependents only, shall be deemed to be an insurer authorized to write insurance under and be subject to this act: Provided, however, That unless its contract with said employer requires it to pay an amount equivalent to the compensation benefits provided by this act, its liability for income benefits or medical and related benefits shall not exceed the amounts of such benefits for which such insurer would have been liable under the workmen's compensation law of such other state;
- (4) If the total amount for which such employer's insurance is liable under clause (3) above is less than the total of the compensation benefits to which such employe is entitled under this act, the secretary may, if he deems it necessary, require the employer to file security, satisfactory to the secretary, to secure the payment of benefits due such employe or his dependents under this act; and
- (5) Upon compliance with the preceding requirements of this subsection (c), such employer, as

to such employe only, shall be deemed to have secured the payment of compensation under this act.

(d) As used in this section:

- (1) "United States" includes only the states of the United States and the District of Columbia.
- (2) "State" includes any state of the United States, the District of Columbia, or any Province of Canada.
- (3) "Carrier" includes any insurance company licensed to write workmen's compensation insurance in any state of the United States or any state or provincial fund which insures employers against their liabilities under a workmen's compensation law.
- (4) A person's employment is principally localized in this or another state when (i) his employer has a place of business in this or such other state and he regularly works at or from such place of business, or (ii) having worked at or from such place of business, his duties have required him to go outside of the State not over one year, or (iii) if clauses (1) and (2) foregoing are not applicable, he is domiciled and spends a substantial part of his working time in the service of his employer in this or such other state.
- (5) An employe whose duties require him to travel regularly in the service of his employer in this and one or more other states may, by written agreement with his employer, provide that his employment is principally localized in this or another such state, and, unless such other state refuses jurisdiction, such agreement shall be given effect under this act.
- (6) "Workmen's compensation law" includes "occupational disease law."

Sec 306 The following schedule of compensation is hereby established:

- (a) (1) For total disability, sixty-six and two-thirds per centum of the wages of the injured employe as defined in section 309 beginning after the seventh day of total disability, and payable for the duration of total disability, but the compensation shall not be more than the maximum compensation payable as defined in section 105.2. Nothing in this clause shall require payment of compensation after disability shall cease. If the benefit so calculated is less than fifty per centum of the Statewide average weekly wage, then the benefit payable shall be the lower of fifty per centum of the Statewide average weekly wage or ninety per centum of the worker's average weekly wage.
 - (2) Nothing in this act shall require payment of total disability compensation benefits under this clause for any period during which the employe is employed or receiving wages.
- (a.1) Nothing in this act shall require payment of compensation under clause (a) or (b) for any period during which the employe is incarcerated after a conviction or during which the employe is employed and receiving wages equal to or greater than the employe's prior earnings.
- (a.2) (1) When an employe has received total disability compensation pursuant to clause (a) for a period of one hundred four weeks, unless otherwise agreed to, the employe shall be required to submit to a medical examination which shall be requested by the insurer within sixty days upon the expiration of the one hundred four weeks to determine the degree of impairment due to the compensable injury, if any. The degree of impairment shall be determined based upon an evaluation by a physician who is licensed in this Commonwealth, who is certified by an American Board of Medical Specialties approved board or its osteopathic equivalent and who is active in clinical practice for at least twenty hours per week, chosen by agreement of the parties, or as designated by the department, pursuant to the most

recent edition of the American Medical Association “Guides to the Evaluation of Permanent Impairment.”

- (2) If such determination results in an impairment rating that meets a threshold impairment rating that is equal to or greater than fifty per centum impairment under the most recent edition of the American Medical Association “Guides to the Evaluation of Permanent Impairment,” the employe shall be presumed to be totally disabled and shall continue to receive total disability compensation benefits under clause (a). If such determination results in an impairment rating less than fifty per centum impairment under the most recent edition of the American Medical Association “Guides to the Evaluation of Permanent Impairment,” the employe shall then receive partial disability benefits under clause (b): Provided, however, That no reduction shall be made until sixty days’ notice of modification is given.
 - (3) Unless otherwise adjudicated or agreed to based upon a determination of earning power under clause (b)(2), the amount of compensation shall not be affected as a result of the change in disability status and shall remain the same. An insurer or employe may, at any time prior to or during the five hundred-week period of partial disability, show that the employe’s earning power has changed.
 - (4) An employe may appeal the change to partial disability at any time during the five hundred-week period of partial disability; Provided, That there is a determination that the employe meets the threshold impairment rating that is equal to or greater than fifty per centum impairment under the most recent edition of the American Medical Association “Guides to the Evaluation of Permanent Impairment.”
 - (5) Total disability shall continue until it is adjudicated or agreed under clause (b) that total disability has ceased or the employe’s condition improves to an impairment rating that is less than fifty per centum of the degree of impairment defined under the most recent edition of the American Medical Association “Guides to the Evaluation of Permanent Impairment.”
 - (6) Upon request of the insurer, the employe shall submit to an independent medical examination in accordance with the provisions of section 314 to determine the status of impairment: Provided, however, That for purposes of this clause, the employe shall not be required to submit to more than two independent medical examinations under this clause during a twelve-month period.
 - (7) In no event shall the total number of weeks of partial disability exceed five hundred weeks for any injury or recurrence thereof, regardless of the changes in status in disability that may occur. In no event shall the total number of weeks of total disability exceed one hundred four weeks for any employe who does not meet a threshold impairment rating that is equal to or greater than fifty per centum impairment under the most recent edition of the American Medical Association “Guides to the Evaluation of Permanent Impairment” for any injury or recurrence thereof.
 - (8) (i) For purposes of this clause, the term “impairment” shall mean an anatomic or functional abnormality or loss that results from the compensable injury and is reasonably presumed to be permanent.
(ii) For purposes of this clause, the term “impairment rating” shall mean the percentage of permanent impairment of the whole body resulting from the compensable injury. The percentage rating for impairment under this clause shall represent only that impairment that is the result of the compensable injury and not for any preexisting work-related or nonwork-related impairment.
- (b) (1) For disability partial in character caused by the compensable injury or disease (except the

particular cases mentioned in clause (c)) sixty-six and two-thirds per centum of the difference between the wages of the injured employe, as defined in section 309, and the earning power of the employe thereafter; but such compensation shall not be more than the maximum compensation payable. This compensation shall be paid during the period of such partial disability except as provided in clause (e) of this section, but for not more than five hundred weeks. Should total disability be followed by partial disability, the period of five hundred weeks shall not be reduced by the number of weeks during which compensation was paid for total disability. The term "earning power," as used in this section, shall in no case be less than the weekly amount which the employe receives after the injury; and in no instance shall an employe receiving compensation under this section receive more in compensation and wages combined than the current wages of a fellow employe in employment similar to that in which the injured employe was engaged at the time of the injury.

- (2) "Earning power" shall be determined by the work the employe is capable of performing and shall be based upon expert opinion evidence which includes job listings with agencies of the department, private job placement agencies and advertisements in the usual employment area. Disability partial in character shall apply if the employe is able to perform his previous work or can, considering the employe's residual productive skill, education, age and work experience, engage in any other kind of substantial gainful employment which exists in the usual employment area in which the employe lives within this Commonwealth. If the employe does not live in this Commonwealth, then the usual employment area where the injury occurred shall apply. If the employer has a specific job vacancy the employe is capable of performing, the employer shall offer such job to the employe. In order to accurately assess the earning power of the employe, the insurer may require the employe to submit to an interview by an expert approved by the department and selected by the insurer.
- (3) If the insurer receives medical evidence that the claimant is able to return to work in any capacity, then the insurer must provide prompt written notice, on a form prescribed by the department, to the claimant, which states all of the following:
 - (i) The nature of the employe's physical condition or change of condition.
 - (ii) That the employe has an obligation to look for available employment.
 - (iii) That proof of available employment opportunities may jeopardize the employe's right to receipt of ongoing benefits.
 - (iv) That the employe has the right to consult with an attorney in order to obtain evidence to challenge the insurer's contentions.
- (c) For all disability resulting from permanent injuries of the following classes, the compensation shall be exclusively as follows:
 - (1) For the loss of a hand, sixty-six and two-thirds per centum of wages during three hundred thirty-five weeks.
 - (2) For the loss of a forearm, sixty-six and two-thirds per centum of wages during three hundred seventy weeks.
 - (3) For the loss of an arm, sixty-six and two-thirds per centum of wages during four hundred ten weeks.
 - (4) For the loss of a foot, sixty-six and two-thirds per centum of wages during two hundred fifty weeks.

- (5) For the loss of a lower leg, sixty-six and two-thirds per centum of wages during three hundred fifty weeks.
- (6) For the loss of a leg, sixty-six and two-thirds per centum of wages during four hundred ten weeks.
- (7) For the loss of an eye, sixty-six and two-thirds per centum of wages during two hundred seventy-five weeks.
- (8)
 - (i) For permanent loss of hearing which is medically established as an occupational hearing loss caused by long-term exposure to hazardous occupational noise, the percentage of impairment shall be calculated by using the binaural formula provided in the Impairment Guides. The number of weeks for which compensation shall be payable shall be determined by multiplying the percentage of binaural hearing impairment as calculated under the Impairment Guides by two hundred sixty weeks. Compensation payable shall be sixty-six and two-thirds per centum of wages during this number of weeks, subject to the provisions of clause (1) of subsection (a) of this section.
 - (ii) For permanent loss of hearing not caused by long-term exposure to hazardous occupational noise which is medically established to be due to other occupational causes such as acoustic trauma or head injury, the percentage of hearing impairment shall be calculated by using the formulas as provided in the Impairment Guides. The number of weeks for which compensation shall be payable for such loss of hearing in one ear shall be determined by multiplying the percentage of impairment by sixty weeks. The number of weeks for which compensation shall be payable for such loss of hearing in both ears shall be determined by multiplying the percentage of impairment by two hundred sixty weeks. Compensation payable shall be sixty-six and two-thirds per centum of wages during this number of weeks, subject to the provisions of clause (1) of subsection (a) of this section.
 - (iii) Notwithstanding the provisions of subclauses (i) and (ii) of this clause, if there is a level of binaural hearing impairment as calculated under the Impairment Guides which is equal to or less than ten per centum, no benefits shall be payable. Notwithstanding the provisions of subclauses (i) and (ii) of this clause, if there is a level of binaural hearing impairment as calculated under the Impairment Guides which is equal to or more than seventy-five per centum, there shall be a presumption that the hearing impairment is total and complete, and benefits shall be payable for two hundred sixty weeks.
 - (iv) The percentage of hearing impairment for which compensation may be payable shall be established solely by audiogram. The audiometric testing must conform to OSHA Occupational Noise Exposure Standards, 29 CFR 1910.95 (relating to occupational noise exposure) and Appendices C, D and E to Part 1910.95 (July 1, 1994).
 - (v) If an employe has previously received compensation under subclause (i) or (ii) of this clause, he may receive additional compensation under subclause (i) or (ii) of this clause for any work-related increase in hearing impairment which occurred after the date of any previous award of or agreement for compensation and only if the increase in hearing impairment is ten percentage points greater than the previous compensated impairment. Any employe who has claimed a complete loss of hearing prior to the effective date of this clause and has received an award or payment for hearing loss shall be barred from claiming compensation for hearing loss or receiving payment therefor pursuant to subclause (i) or (ii) of this clause.
 - (vi) An employer shall be liable only for the hearing impairment caused by such employer.

If previous occupational hearing impairment or hearing impairment from nonoccupational causes is established at or prior to the time of employment, the employer shall not be liable for the hearing impairment so established whether or not compensation has previously been paid or awarded.

- (vii) An employer may require an employe to undergo audiometric testing at the expense of the employer from time to time. If an employer chooses to require an employe to undergo audiometric testing, the employer shall be required to notify the employe in writing that unless the employe submits to audiometric testing at the expense of and at the request of the employer, the employe shall lose the right to pursue a claim for occupational hearing loss against that employer. Any employe who undergoes audiometric testing at the direction of an employer may request a copy and a brief explanation of the results which shall be provided to the employe within thirty days of the date they are available.
 - (viii) Whenever an occupational hearing loss caused by long-term exposure to hazardous occupational noise is the basis for compensation or additional compensation, the claim shall be barred unless a petition is filed within three years after the date of last exposure to hazardous occupational noise in the employ of the employer against whom benefits are sought.
 - (ix) The date of injury for occupational hearing loss under subclause (i) of this clause shall be the earlier of the date on which the claim is filed or the last date of long-term exposure to hazardous occupational noise while in the employ of the employer against whom the claim is filed.
 - (x) Whether the employe has been exposed to hazardous occupational noise or has long-term exposure to such noise shall be affirmative defenses to a claim for occupational hearing loss and not a part of the claimant's burden of proof in a claim.
 - (xi) The healing period provided for under clause (25) of this subsection shall not be applicable to any hearing loss under subclause (i) or (ii) of this clause.
- (9) For the loss of a thumb, sixty-six and two-thirds per centum of wages during one hundred weeks.
 - (10) For the loss of a first finger, commonly called index finger, sixty-six and two-thirds per centum of wages during fifty weeks.
 - (11) For the loss of a second finger, sixty-six and two-thirds per centum of wages during forty weeks.
 - (12) For the loss of a third finger, sixty-six and two-thirds per centum of wages during thirty weeks.
 - (13) For the loss of a fourth finger, commonly called little finger, sixty-six and two-thirds per centum of wages during twenty-eight weeks.
 - (14) The loss of the first phalange of the thumb shall be considered the loss of the thumb. The loss of a substantial part of the first phalange of the thumb shall be considered the loss of one-half of the thumb.
 - (15) The loss of any substantial part of the first phalange of a finger, or an amputation immediately below the first phalange for the purpose of providing an optimum surgical result, shall

be considered loss of one-half of the finger. Any greater loss shall be considered the loss of the entire finger.

- (16) The loss of one-half of the thumb, or a finger, shall be compensated at the same rate as for the loss of a thumb or finger but for one-half of the period provided for the loss of a thumb or finger.

For the loss of, or permanent loss of the use of, any two or more such members, not constituting total disability, sixty-six and two-thirds per centum of wages during the aggregate of the periods specified for each.

- (17) For the loss of a great toe, sixty-six and two-thirds per centum of wages during forty weeks.
- (18) For the loss of any other toe, sixty-six and two-thirds per centum of wages during sixteen weeks.
- (19) The loss of the first phalange of the great toe, or of any toe, shall be considered equivalent to the loss of one-half of such great toe, or other toe, and shall be compensated at the same rate as for the loss of a great toe, or other toe, but for one-half of the period provided for the loss of a great toe or other toe.
- (20) The loss of more than one phalange of a great toe, or any toe, shall be considered equivalent to the loss of the entire great toe or other toe.
- (21) For the loss of, or permanent loss of the use of any two or more such members, not constituting total disability, sixty-six and two-thirds per centum of wages during the aggregate of the periods specified for each.
- (22) For serious and permanent disfigurement of the head, neck or face, of such a character as to produce an unsightly appearance, and such as is not usually incident to the employment, sixty-six and two-thirds per centum of wages not to exceed two hundred seventy-five weeks.
- (23) Unless the board shall otherwise determine, the loss of both hands or both arms or both feet or both legs or both eyes shall constitute total disability, to be compensated according to the provisions of clause (a).
- (24) Amputation at the wrist shall be considered as the equivalent of the loss of a hand, and amputation at the ankle shall be considered as the equivalent of the loss of a foot. Amputation between the wrist and the elbow shall be considered as the loss of a forearm, and amputation between the ankle and the knee shall be considered as the loss of a lower leg. Amputation at or above the elbow shall be considered as the loss of an arm and amputation at or above the knee shall be considered as the loss of a leg. Permanent loss of the use of a hand, arm, foot, leg, eye, finger, or thumb, great toe or other toe, shall be considered as the equivalent of the loss of such hand, arm, foot, leg, eye, finger, or thumb, great toe or other toe.
- (25) In addition to the payments hereinbefore provided for permanent injuries of the classes specified, any period of disability necessary and required as a healing period shall be compensated in accordance with the provisions of this subsection. The healing period shall end (i) when the claimant returns to employment without impairment in earnings, or (ii) on the last day of the period specified in the following table, whichever is the earlier;

For the loss of a hand, twenty weeks.

For the loss of a forearm, twenty weeks.

For the loss of an arm, twenty weeks.

For the loss of a foot, twenty-five weeks.

For the loss of the lower leg, twenty-five weeks.

For the loss of a leg, twenty-five weeks.

For the loss of an eye, ten weeks.

For the loss of hearing, ten weeks.

For the loss of a thumb or any part thereof, ten weeks.

For the loss of any other finger or any part thereof, six weeks.

For the loss of a great toe or any part thereof, twelve weeks.

For the loss of any other toe or any part thereof, six weeks.

Compensation under paragraphs (1) through (24) of this clause shall not be more than the maximum compensation payable nor less than fifty per centum of the maximum compensation payable per week for total disability as provided in subsection (a) of this section, but in no event more than the Statewide average weekly wage.

Compensation for the healing period under paragraph (25) of this clause shall be computed as provided in clause (a) of this section. When an employe works during the healing period, his wages and earning power shall be as defined in this act and he shall not receive more in wages and compensation combined than his wages at the time of the injury as defined in section three hundred and nine. Where any such permanent injury or injuries shall require an amputation at any time after the end of the healing period hereinbefore provided, the employe shall be entitled to receive compensation for the second healing period, and in the case of a second injury or amputation to the same limb prior to the expiration of the first healing period a new healing period shall commence for the period hereinbefore provided, and no further compensation shall be payable for the first healing period.

- (d) Where, at the time of the injury the employe receives other injuries, separate from these which result in permanent injuries enumerated in clause (c) of this section, the number of weeks for which compensation is specified for the permanent injuries shall begin at the end of the period of temporary total disability which results from the other separate injuries, but in that event the employe shall not receive compensation provided in clause (c) of this section for the specific healing period. In the event the employe suffers two or more permanent injuries of the above enumerated classes compensable under clause (c) of this section, he shall be compensated for the largest single healing period rather than the aggregate of the healing periods.
- (e) No compensation shall be allowed for the first seven days after disability begins, except as provided in this clause (e) and clause (f) of this section. If the period of disability lasts fourteen days or more, the employe shall also receive compensation for the first seven days of disability.
- (f.1) (1) (i) 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. Provided an employer establishes a list of at least six designated health care providers, no more than four of whom may be a

coordinated care organization and no fewer than three of whom shall be physicians, the employe shall be required to visit one of the physicians or other health care providers so designated and shall continue to visit the same or another designated physician or health care provider for a period of ninety (90) days from the date of the first visit: Provided, however, That the employer shall not include on the list 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. Should invasive surgery for an employe be prescribed by a physician or other health care provider so designated by the employer, the employe shall be permitted to receive an additional opinion from any health care provider of the employe's own choice. If the additional opinion differs from the opinion provided by the physician or health care provider so designated by the employer, the employe shall determine which course of treatment to follow: Provided, That the second opinion provides a specific and detailed course of treatment. If the employe chooses to follow the procedures designated in the second opinion, such procedures shall be performed by one of the physicians or other health care providers so designated by the employer for a period of ninety (90) days from the date of the visit to the physician or other health care provider of the employe's own choice. Should the employe not comply with the foregoing, the employer will be relieved from liability for the payment for the services rendered during such applicable period. It shall be the duty of the employer to provide a clearly written notification of the employe's rights and duties under this section to the employe. The employer shall further ensure that the employe has been informed and that he understands these rights and duties. This duty shall be evidenced only by the employe's written acknowledgment of having been informed and having understood his rights and duties. Any failure of the employer to provide and evidence such notification shall relieve the employe from any notification duty owed, notwithstanding any provision of this act to the contrary, and the employer shall remain liable for all rendered treatment. Subsequent treatment may be provided by any health care provider of the employe's own choice. Any employe who, next following termination of the applicable period, is provided treatment from a nondesignated health care provider shall notify the employer within five (5) days of the first visit to said health care provider. Failure to so notify the employer will relieve the employer from liability for the payment for the services rendered prior to appropriate notice if such services are determined pursuant to paragraph (6) to have been unreasonable or unnecessary.

- (ii) In addition to the above service, the employer shall provide payment for medicines and supplies, hospital treatment, services and supplies and orthopedic appliances, and prostheses in accordance with this section. Whenever an employe shall have suffered the loss of a limb, part of a limb, or an eye, the employer shall also provide for an artificial limb or eye or other prostheses of a type and kind recommended by the doctor attending such employe in connection with such injury and any replacements for an artificial limb or eye which the employe may require at any time thereafter, together with such continued medical care as may be prescribed by the doctor attending such employe in connection with such injury as well as such training as may be required in the proper use of such prostheses. The provisions of this section shall apply to injuries whether or not loss of earning power occurs. If hospital confinement is required, the employe shall be entitled to semiprivate accommodations, but, if no such facilities are available, regardless of the patient's condition, the employer, not the patient, shall be liable for the additional costs for the facilities in a private room.
 - (iii) Nothing in this section shall prohibit an insurer or an employer from contracting with any individual, partnership, association or corporation to provide case management and coordination of services with regard to injured employes.
- (2) Any provider who treats an injured employe shall be required to file periodic reports with

the employer on a form prescribed by the department which shall include, where pertinent, history, diagnosis, treatment, prognosis and physical findings. The report shall be filed within ten (10) days of commencing treatment and at least once a month thereafter as long as treatment continues. The employer shall not be liable to pay for such treatment until a report has been filed.

- (3) (i) For purposes of this clause, a provider shall not require, request or accept payment for the treatment, accommodations, products or services in excess of one hundred thirteen per centum of the prevailing charge at the seventy-fifth percentile; one hundred thirteen per centum of the applicable fee schedule, the recommended fee or the inflation index charge; one hundred thirteen per centum of the DRG payment plus pass-through costs and applicable cost or day outliers; or one hundred thirteen per centum of any other Medicare reimbursement mechanism, as determined by the Medicare carrier or intermediary, whichever pertains to the specialty service involved, determined to be applicable in this Commonwealth under the Medicare program for comparable services rendered. If the commissioner determines that an allowance for a particular provider group or service under the Medicare program is not reasonable, it may adopt, by regulation, a new allowance. If the prevailing charge, fee schedule, recommended fee, inflation index charge, DRG payment or any other reimbursement has not been calculated under the Medicare program for a particular treatment, accommodation, product or service, the amount of the payment may not exceed eighty per centum of 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.
- (ii) Commencing on January 1, 1995, the maximum allowance for a health care service covered by subparagraph (i) shall be updated as of the first day of January of each year. The update, which shall be applied to all services performed after January 1 of each year, shall be equal to the percentage change in the Statewide average weekly wage. Such updates shall be cumulative.
- (iii) 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 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.
- (iv) The secretary shall retain the services of an independent consulting firm to perform an annual accessibility study of health care provided under this act. The study shall include information as to whether there is adequate access to quality health care and products for injured workers and a review of the information that is provided. If the secretary determines based on this study that as a result of the health care fee schedule there is not sufficient access to quality health care or products for persons suffering injuries covered by this act, the secretary may recommend to the commissioner the adoption of regulations providing for a new allowance.
- (v) An allowance shall be reviewed for reasonableness whenever the commissioner determines that the use of the allowance would result in payments more than ten per centum lower than the average level of reimbursement the provider would receive

from coordinated care insurers, including those entities subject to the act of December 29, 1972 (P.L.1701, No.364), known as the “Health Maintenance Organization Act,” and those entities known as preferred provider organizations which are subject to section 630 of the Insurance Company Law of 1921 for like treatments, accommodations, products or services. In making this determination, the commissioner shall consider the extent to which allowances applicable to other providers under this section deviate from the reimbursement such providers would receive from coordinated care insurers. Any information received as a result of this subparagraph shall be confidential.

- (vi) The reimbursement for prescription drugs and professional pharmaceutical services shall be limited to one hundred ten per centum of the average wholesale price of the product.
 - (vii) The applicable Medicare fee schedule shall include fees associated with all permissible procedure codes. If the Medicare fee schedule also includes a larger grouping of procedure codes and corresponding charges than are specifically reimbursed by Medicare, a provider may use these codes, and corresponding charges shall be paid by insurers or employers. If a Medicare code exists for application to a specific provider specialty, that code shall be used.
 - (viii) A provider shall not fragment or unbundle charges imposed for specific care except as consistent with Medicare. Changes to a provider’s codes by an insurer shall be made only as consistent with Medicare and when the insurer has sufficient information to make the changes and following consultation with the provider.
- (4) Nothing in this act shall prohibit the self-insured employer, employer or insurer from contracting with a coordinated care organization for reimbursement levels different from those identified above.
 - (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). 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.
 - (6) 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 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 per-

formed 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.

- (ii) The utilization review organization shall issue a written report of its findings and conclusions within thirty (30) days of a request.
 - (iii) The employer or the insurer shall pay the cost of the utilization review.
 - (iv) 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 thirty (30) days after receipt of the report. The department shall assign the petition to a workers' compensation judge for a hearing or for an informal conference under section 402.1. The utilization review report shall be part of the record before the workers' compensation judge. The workers' compensation judge shall consider the utilization review report as evidence but shall not be bound by the report.
- (7) A provider shall not hold an employee 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 employee the difference between the provider's charge and the amount paid by the employer or the insurer.
- (8) If the employee shall refuse reasonable services of health care providers, surgical, medical and hospital services, treatment, medicines and supplies, he shall forfeit all rights to compensation for any injury or increase in his incapacity shown to have resulted from such refusal.
- (9) The payment by an insurer or employer for any medical, surgical or hospital services or supplies after any statute of limitations provided for in this act shall have expired shall not act to reopen or revive the compensation rights for purposes of such limitations.
- (10) If acute care is provided in an acute care facility to a patient with an immediately life threatening or urgent injury by a Level I or Level II trauma center accredited by the Pennsylvania Trauma Systems Foundation under the act of July 3, 1985 (P.L.164, No.45), known as the "Emergency Medical Services Act," or to a burn injury patient by a burn facility which meets all the service standards of the American Burn Association, or if basic or advanced life support services, as defined and licensed under the "Emergency Medical Services Act," are provided, the amount of payment shall be the usual and customary charge.
- (f.2) (1) Medical services required by the act may be provided through a coordinated care organization which is certified by the secretary subject to the following:
- (i) Each application for certification shall be accompanied by a reasonable fee prescribed by the department. A certificate is valid for such period as the department may prescribe unless sooner revoked or suspended.
 - (ii) Application for certification shall be made in such form and manner as the department shall require and shall set forth information regarding the proposed plan for providing services.
 - (iii) Where the secretary certifies that the coordinated care organization within which all of the designated physicians or other health care providers referred to in clause (f.1)(1)(i) are members, the secretary shall ensure that all the requirements of this clause are met.

- (2) The coordinated care organization shall include an adequate number and specialty distribution of licensed health care providers in order to assure appropriate and timely delivery of services required under the act and an appropriate flexibility to workers in selecting providers. Services may be provided directly, through affiliates or through contractual referral arrangements with other health care providers.
- (3) The secretary shall certify an entity as a coordinated care organization if the secretary finds that the entity:
 - (i) Possesses the capacity to provide all primary medical services as designated by the secretary in a manner that is timely and effective.
 - (ii) Maintains a referral capacity to treat other injuries and illnesses not covered by primary services but which are covered by this act.
 - (iii) Provides a case management and evaluation system which includes continuous monitoring of treatment from onset of injury or illness until final resolution.
 - (iv) Provides a case communication system which relates necessary and appropriate information among the employee, employer, health care providers and insurer.
 - (v) Provides appropriate peer and utilization review and a care dispute resolution system.
 - (vi) Meets quality of care and cost-effectiveness standards based upon accepted standards in the profession, including health care effectiveness measures of the Pennsylvania Health Care Cost Containment Council and recommendations on quality of care by the Workers' Compensation Advisory Council.
 - (vii) Complies with any other requirements of law regarding delivery of health care services.
 - (viii) Establishes a written grievance procedure for prompt and effective resolution of patient grievances.
- (4) The secretary shall refuse to certify or may revoke or suspend certification of any coordinated care organization if the secretary finds that:
 - (i) the plan for providing health care services fails to meet the requirements of this section;
 - (ii) service under the plan is not being provided in accordance with terms of the plan as certified; or
 - (iii) services under the plan do not meet accepted professional standards for quality, cost-effective health care.
- (5) A person participating in utilization review, quality assurance or peer review activities pursuant to this section shall not be examined as to any communication made in the course of such activities or the findings thereof, nor shall any person be subject to an action for civil damages for actions taken or statements made in good faith.
- (6) Health care providers designated as rural by HCFA or located in a county with a rural Health Professional Shortage Area who are attempting to form or operate a coordinated care organization may be excluded from meeting some or all of the minimum requirements set forth in paragraphs (2) and (3) of this clause, as shall be determined in rules or regulations promulgated by the department.

- (7) The department shall have the power and authority to promulgate, adopt, publish and use regulations for the implementation of this section.
- (g) Should the employe die from some other cause than the injury, payments of compensation to which the deceased would have been entitled to under section 306(c)(1) to (25) shall be paid to the following persons who at the time of the death of the deceased were dependents within the definition of clause (7) of section 307 and in the following order and amounts:
- (1) To the surviving widow or widower if there are no children under the age of eighteen.
 - (2) To a surviving widow or widower and a surviving child or children in which event the widow or widower shall receive one-half and the surviving child or children shall receive the other half.
 - (3) To a surviving child or children if there is no surviving widow or widower.
 - (4) If there is no surviving widow or widower and no surviving child or children of the deceased then to that dependent or those dependents named in clause (5) of section 307.
 - (5) If there are no persons eligible as named above or in those classes then to those persons who are named in clause (6) of section 307.
 - (6) When such compensation is paid to dependents above named, compensation shall not cease even though the person receiving the payments ceases to be a dependent as defined in section 307.
 - (7) If there be no dependents eligible to receive payments under this section then the payment shall be made to the estate of the deceased but in an amount not exceeding reasonable funeral expenses as provided in this act or if there be no estate, to the person or persons paying the funeral expenses of such deceased in an amount not exceeding reasonable funeral expenses as provided in this act.
- (h) Any person receiving compensation under sections 306(a), 306(b), 306(c)(23), or section 307, as a result of an accident which occurred prior to the effective date of the amendatory act of January 17, 1968 (P.L. 6, No. 4) shall have the compensation rate adjusted to the level they would have received had the injury occurred on the effective date of the amendatory act of January 17, 1968 (P.L. 6, No. 4) and had the injured employe been earning wages equal to ninety dollars (\$90) per week. The additional compensation shall be paid by the self-insured employer or insurance carrier making payment and shall be reimbursed in advance by the Commonwealth on a quarterly basis as provided in rules and regulations of the department. The payment of additional compensation shall be made by the carrier or self-insured employer only during those fiscal years for which appropriations are made to cover reimbursement.

Sec 306.1 If an employe, who has incurred (through injury or otherwise) permanent partial disability, through the loss, or loss of use of, one hand, one arm, one foot, one leg or one eye, incurs total disability through a subsequent injury, causing loss, or loss of use of, another hand, arm, foot, leg or eye, he shall be entitled to additional compensation as follows:

After the cessation of payments by the employer for the period of weeks prescribed in Clause (c) of section 306, for the subsequent injury, additional compensation shall be paid during the continuance of total disability, at the weekly compensation rate applicable for total disability. This additional compensation shall be paid by the department out of the Subsequent Injury Fund created pursuant to section 306.2. All claims for such additional compensation shall be forever barred unless the employe shall have filed a petition therefor with the department in the same manner and within the same time as provided in section 315 with respect to other injuries. Where, however, a person is receiving benefits pursuant to the

act of June 28, 1935 (P.L. 477, No. 193), referred to as the Heart and Lung Act, the two-year period in which parties must file a petition for additional compensation, shall not begin to run until the expiration of the receipt of benefits pursuant to the Heart and Lung Act.

The Department of Labor and Industry shall be charged with the conservation of the assets of said appropriation. In furtherance of this purpose, the Attorney General shall appoint a member of his staff to represent the Subsequent Injury Fund in all proceedings brought to enforce claims against such fund. In its award the Department of Labor and Industry shall specifically find the amount the injured employe shall be paid weekly, the number of weeks compensation which shall be paid by the employer, the date upon which payments shall begin, and if possible the length of time such payments shall continue.

Any benefits received by any employe, or to which he may be entitled, by reason of such increased disability, from any State or Federal fund or agency to which said employe has not directly contributed, shall be regarded as a credit to any award made against the Commonwealth as aforesaid, excepting those benefits received by an employe by reason of service connected physical injuries, incurred during any war between the United States of America and any foreign country.

Sec 306.2 The sum of one hundred thousand dollars (\$100,000) is hereby appropriated to the Department of Labor and Industry for the Subsequent Injury Fund by the Commonwealth for the 1971-1972 fiscal year and this fund shall be maintained at one hundred thousand dollars (\$100,000) by assessing each insurer a proportion of the amount expended from the fund during the preceding year, that the total compensation paid by such insurers during such year bore to the total compensation paid by all insurers that year: Provided, however, That in the first year in which assessments are made under this provision, the total amount assessed and collected shall be two hundred per centum of the amount paid in such cases during the preceding year.

[Editor's Note: See "Additional Relevant Statutory Provisions," Appendix C, (8).]

Sec 307 In case of death, compensation shall be computed on the following basis, and distributed to the following persons: Provided, That in no case shall the wages of the deceased be taken to be less than fifty per centum of the Statewide average weekly wage for purposes of this section:

1. If there be no widow nor widower entitled to compensation, compensation shall be paid to the guardian of the child or children or, if there be no guardian, to such other persons as may be designated by the board as hereinafter provided as follows:
 - (a) If there be one child, thirty-two per centum of wages of deceased, but not in excess of the Statewide average weekly wage.
 - (b) If there be two children, forty-two per centum of wages of deceased, but not in excess of the Statewide average weekly wage.
 - (c) If there be three children, fifty-two per centum of wages of deceased, but not in excess of the Statewide average weekly wage.
 - (d) If there be four children, sixty-two per centum of wages of deceased, but not in excess of the Statewide average weekly wage.
 - (e) If there be five children, sixty-four per centum of wages of deceased, but not in excess of the Statewide average weekly wage.
 - (f) If there be six or more children, sixty-six and two-thirds per centum of wages of deceased, but not in excess of the Statewide average weekly wage.

2. To the widow or widower, if there be no children, fifty-one per centum of wages, but not in excess of the Statewide average weekly wage.
3. To the widow or widower, if there be one child, sixty per centum of wages, but not in excess of the Statewide average weekly wage.
4. To the widow or widower, if there be two children, sixty-six and two-thirds per centum of wages but not in excess of the Statewide average weekly wage.
- 4½. To the widow or widower, if there be three or more children, sixty-six and two-thirds per centum of wages, but not in excess of the Statewide average weekly wage.
5. If there be neither widow, widower, nor children entitled to compensation, then to the father or mother, if dependent to any extent upon the employe at the time of the injury, thirty-two per centum of wages but not in excess of the Statewide average weekly wage: Provided, however, That in the case of a minor child who has been contributing to his parents, the dependency of said parents shall be presumed: And provided further, That if the father and mother was totally dependent upon the deceased employe at the time of the injury, the compensation payable to such father or mother shall be fifty-two per centum of wages, but not in excess of the Statewide average weekly wage.
6. If there be neither widow, widower, children, nor dependent parent, entitled to compensation, then to the brothers and sisters, if actually dependent upon the decedent for support at the time of his death, twenty-two per centum of wages for one brother or sister, and five per centum additional for each additional brother or sister, with a maximum of thirty-two per centum of wages of deceased, but not in excess of the Statewide average wage, such compensation to be paid to their guardian, or if there be no guardian, to such other person as may be designated by the board, as hereinafter provided.
7. Whether or not there be dependents as aforesaid, the reasonable expense of burial, not exceeding three thousand dollars (\$3,000), which shall be paid by the employer or insurer directly to the undertaker (without deduction of any amounts theretofore paid for compensation or for medical expenses).

Compensation shall be payable under this section to or on account of any child, brother, or sister, only if and while such child, brother, or sister, is under the age of eighteen unless such child, brother or sister is dependent because of disability when compensation shall continue or be paid during such disability of a child, brother or sister over eighteen years of age or unless such child is enrolled as a full-time student in any accredited educational institution when compensation shall continue until such student becomes twenty-three. No compensation shall be payable under this section to a widow, unless she was living with her deceased husband at the time of his death, or was then actually dependent upon him and receiving from him a substantial portion of her support. No compensation shall be payable under this section to a widower, unless he be incapable of self-support at the time of his wife's death and be at such time dependent upon her for support. If members of decedent's household at the time of his death, the terms "child" and "children" shall include step-children, adopted children and children to whom he stood in loco parentis, and children of the deceased and shall include posthumous children. Should any dependent of a deceased employe die or remarry, or should the widower become capable of self-support, the right of such dependent or widower to compensation under this section shall cease except that if a widow remarries, she shall receive one hundred four weeks compensation at a rate computed in accordance with clause 2. of section 307 in a lump sum after which compensation shall cease: Provided, however, That if, upon investigation and hearing, it shall be ascertained that the widow or widower is living with a man or woman, as the case may be, in meretricious relationship and not married, or the widow living a life of prostitution, the board may order the termination of compensation payable to such widow or widower. If the compensation payable under this section to any

person shall, for any cause, cease, the compensation to the remaining persons entitled thereunder shall thereafter be the same as would have been payable to them had they been the only persons entitled to compensation at the time of the death of the deceased.

The board may, if the best interest of a child or children shall so require, at any time order and direct the compensation payable to a child or children, or to a widow or widower on account of any child or children, to be paid to the guardian of such child or children, or, if there be no guardian, to such other person as the board as hereinafter provided may direct. If there be no guardian or committee of any minor, dependent, or insane employe, or dependent, on whose account compensation is payable, the amount payable on account of such minor, dependent, insane employe, or dependent may be paid to any surviving parent, or such other person as the board may order and direct, and the board may require any person, other than a guardian or committee, to whom it has directed compensation for a minor, dependent, or insane employe, or dependent to be paid, to render, as and when it shall so order, accounts of the receipts and disbursements of such person, and to file with it a satisfactory bond in a sum sufficient to secure the proper application of the moneys received by such person.

Sec 308 Except as hereinafter provided, all compensation payable under this article shall be payable in periodical installments, as the wages of the employe were payable before the injury.

Sec 308.1 (a) The eligibility of professional athletes for compensation under this act shall be limited as provided in this section.

(b) The term "professional athlete," as used in this section, shall mean a natural person employed as a professional athlete by a franchise of the National Football League, the National Basketball Association, the National Hockey League, the National League of Professional Baseball Clubs or the American League of Professional Baseball Clubs, under a contract for hire or a collective bargaining agreement, whose wages as defined in section 309 are more than eight times the Statewide average weekly wage.

(c) In the case of a professional athlete, any compensation payable under this act with respect to partial disability shall be reduced by the after-tax amount of any:

(1) Wages payable by the employer during the period of disability under a contract for hire or collective bargaining agreement.

(2) Payments under a self-insurance, wage continuation, disability insurance or similar plan funded by the employer.

(3) Injury protection or other injury benefits payable by the employer under a contract for hire or collective bargaining agreement.

(d) No reduction shall be made pursuant to clause (c) against any compensation payable under this act which becomes due and payable on a date after the expiration or termination of the professional athlete's employment contract, except for any amounts paid by the employer pursuant to the contract.

(e) In the case of a professional athlete, the term "wages of the injured employe" as used in section 306(b) for the purpose of computing compensation for partial disability shall mean two times the Statewide average weekly wage.

Sec 309 Wherever in this article the term "wages" is used, it shall be construed to mean the average weekly wages of the employe, ascertained as follows:

(a) If at the time of the injury the wages are fixed by the week, the amount so fixed shall be the average weekly wage;

- (b) If at the time of the injury the wages are fixed by the month, the average weekly wage shall be the monthly wage so fixed multiplied by twelve and divided by fifty-two;
- (c) If at the time of the injury the wages are fixed by the year, the average weekly wage shall be the yearly wage so fixed divided by fifty-two;
- (d) If at the time of the injury the wages are fixed by any manner not enumerated in clause (a), (b) or (c), the average weekly wage shall be calculated by dividing by thirteen the total wages earned in the employ of the employer in each of the highest three of the last four consecutive periods of thirteen calendar weeks in the fifty-two weeks immediately preceding the injury and by averaging the total amounts earned during these three periods.
 - (d.1) If the employe has not been employed by the employer for at least three consecutive periods of thirteen calendar weeks in the fifty-two weeks immediately preceding the injury, the average weekly wage shall be calculated by dividing by thirteen the total wages earned in the employ of the employer for any completed period of thirteen calendar weeks immediately preceding the injury and by averaging the total amounts earned during such periods.
 - (d.2) If the employe has worked less than a complete period of thirteen calendar weeks and does not have fixed weekly wages, the average weekly wage shall be the hourly wage rate multiplied by the number of hours the employe was expected to work per week under the terms of employment.
- (e) Except as provided in clause (d.1) or (d.2), in occupations which are exclusively seasonal and therefore cannot be carried on throughout the year, the average weekly wage shall be taken to be one-fiftieth of the total wages which the employe has earned from all occupations during the twelve calendar months immediately preceding the injury, unless it be shown that during such year, by reason of exceptional causes, such method of computation does not ascertain fairly the earnings of the employe, in which case the period for calculation shall be extended so far as to give a basis for the fair ascertainment of his average weekly earnings.

The terms "average weekly wage" and "total wages," as used in this section, shall include board and lodging received from the employer, and gratuities reported to the United States Internal Revenue Service by or for the employe for Federal income tax purposes, but such terms shall not include amounts deducted by the employer under the contract of hiring for labor furnished or paid for by the employer and necessary for the performance of such contract by the employe, nor shall such terms include deductions from wages due the employer for rent and supplies necessary for the employe's use in the performance of his labor, nor shall such terms include fringe benefits, including, but not limited to, employer payments for or contributions to a retirement, pension, health and welfare, life insurance, social security or any other plan for the benefit of the employe or his dependents: Provided, however, That the amount of any bonus, incentive or vacation payment earned on an annual basis shall be excluded from the calculations under clauses (a) through (d.2). Such payments if any shall instead be divided by fifty-two and the amount shall be added to the average weekly wage otherwise calculated under clauses (a) through (d.2).

Where the employe is working under concurrent contracts with two or more employers, his wages from all such employers shall be considered as if earned from the employer liable for compensation.

Sec 310

Alien widows, children and parents, not residents of the United States, shall be entitled to compensation, but only to the amount of fifty per centum of the compensation which would have been payable if they were residents of the United States: Provided, That compensation benefits are granted residents of the United States under the laws of the foreign country in which the widow, children or parents reside. Alien widowers, brothers and sisters who are not residents of the United States shall not be entitled to receive any compensation. In no event shall any nonresident alien widow or parent be entitled to compensation

in the absence of proof that the alien widow or parent has actually been receiving a substantial portion of his or her support from the decedent. Where transmission of funds in payment of any such compensation is prohibited by any law of the Commonwealth or of the United States to residents of such foreign country, then no compensation shall accrue or be payable while such prohibition remains in effect and, unless such prohibition is removed within six years from the date of death, all obligation to pay compensation under this section shall be forever extinguished.

In every instance where an award is made to alien widows, children or parents, not residents in the United States, the referee or the board shall, in the award, fix the amount of any fee allowed to any person for services in connection with presenting the claim, and it shall be a misdemeanor punishable by a fine of not more than five hundred dollars, or imprisonment for not more than six months, or both, to accept any remuneration for the services other than that provided by the referee or board.

Sec 311 Unless the employer shall have knowledge of the occurrence of the injury, or unless the employe or someone in his behalf, or some of the dependents or someone in their behalf, shall give notice thereof to the employer within twenty-one days after the injury, no compensation shall be due until such notice be given, and, unless such notice be given within one hundred and twenty days after the occurrence of the injury, no compensation shall be allowed. However, in cases of injury resulting from ionizing radiation or any other cause in which the nature of the injury or its relationship to the employment is not known to the employe, the time for giving notice shall not begin to run until the employe knows, or by the exercise of reasonable diligence should know, of the existence of the injury and its possible relationship to his employment. The term "injury" in this section means, in cases of occupational disease, disability resulting from occupational disease.

- Sec 311.1 (a) If an employe files a petition seeking compensation under section 306(a) or (b) or is receiving compensation under section 306(a) or (b), the employe shall report, in writing, to the insurer the following:
- (1) If the employe has become or is employed or self-employed in any capacity.
 - (2) Any wages from such employment or self-employment.
 - (3) The name and address of the employer.
 - (4) The amount of wages from such employment or self-employment.
 - (5) The dates of such employment or self-employment.
 - (6) The nature and scope of such employment or self-employment.
 - (7) Any other information which is relevant in determining the entitlement to or amount of compensation.
- (b) The report referred to in clause (a) must be made as soon as possible but no later than thirty days after such employment or self-employment occurs.
- (c) An employe is obligated to cooperate with the insurer in an investigation of employment, self-employment, wages and physical condition.
- (d) If an employe files a petition seeking compensation under section 306(a) or (b) or is receiving compensation under section 306(a) or (b), the insurer may submit a verification form to the employe either by mail or in person. The form shall request verification by the employe that the employe's status regarding the entitlement to receive compensation has not changed and a notation of any changes of which the employe is aware at the time the employe completes the verification, including employment, self-employment, wages and change in physical condition. Such verification shall not

require any evaluation by a third party; however, it shall include a certification evidenced by the employe's signature that the statement is true and correct and that the claimant is aware of the penalties provided by law for making false statements for the purpose of obtaining compensation.

- (e) The employe is obligated to complete accurately the verification form and return it to the insurer within thirty days of receipt by the employe of the form. However, the use of the verification form by the insurer and the employe's completion of such form do not relieve the employe of obligations under clauses (a), (b) and (c).
- (f) The insurer may require the employe to complete the verification form at intervals of no less than six months.
- (g) If the employe fails to return the completed verification form within thirty days, the insurer is permitted to suspend compensation until the completed verification form is returned. The verification form utilized by the insurer shall clearly provide notice to the employe that failure to complete the form within thirty days may result in a suspension of compensation payments.

Sec 312 The notice referred to in section 311 shall inform the employer that a certain employe received an injury, described in ordinary language, in the course of his employment on or about a specified time, at or near a place specified.

Sec 313 The notice referred to in sections 311 and 312 may be given to the immediate or other superior of the employe, to the employer, or any agent of the employer regularly employed at the place of employment of the injured employe. Knowledge of the occurrence of the injury on the part of any such agents shall be the knowledge of the employer.

Sec 314 (a) At any time after an injury the employe, if so requested by his employer, must submit himself at some reasonable time and place for a physical examination or expert interview by an appropriate health care provider or other expert, who shall be selected and paid for by the employer. If the employe shall refuse upon the request of the employer, to submit to the examination or expert interview by the health care provider or other expert selected by the employer, a workers' compensation judge assigned by the department may, upon petition of the employer, order the employe to submit to such examination or expert interview at a time and place set by the workers' compensation judge and by the health care provider or other expert selected and paid for by the employer or by a health care provider or other expert designated by the workers' compensation judge and paid for by the employer. The workers' compensation judge may at any time after such first examination or expert interview, upon petition of the employer, order the employe to submit himself to such further physical examinations or expert interviews as the workers' compensation judge shall deem reasonable and necessary, at such times and places and by such health care provider or other expert as the workers' compensation judge may designate; and in such case, the employer shall pay the fees and expenses of the examining health care provider or other expert, and the reasonable traveling expenses and loss of wages incurred by the employe in order to submit himself to such examination or expert interview. The refusal or neglect, without reasonable cause or excuse, of the employe to submit to such examination or expert interview ordered by the workers' compensation judge, either before or after an agreement or award, shall deprive him of the right to compensation, under this article, during the continuance of such refusal or neglect, and the period of such neglect or refusal shall be deducted from the period during which compensation would otherwise be payable.

- (b) In the case of a physical examination, the employe shall be entitled to have a health care provider of his own selection, to be paid by him, participate in such examination requested by his employer or ordered by the workers' compensation judge. In instances where an examination is requested in relation to section 306(a.2)(1), such examination shall be performed by a physician who is licensed in this Commonwealth, who is certified by an American Board of Medical Specialties approved board or its osteopathic equivalent and who is in active clinical practice for at least twenty (20) hours per week.

[Editor's Note: Section 315 has been reproduced twice to more accurately reflect the actual amendments of this section in 1974. Act 56 added the references to the Heart and Lung Act, while Act 263 extended the time for filing a claim for injury from two years to three years.]

Sec 315 In cases of personal injury all claims for compensation shall be forever barred, unless, within two years after the injury, the parties shall have agreed upon the compensation payable under this article; or unless within two years after the injury, one of the parties shall have filed a petition as provided in article four hereof. In cases of death all claims for compensation shall be forever barred, unless within two years after the death, the parties shall have agreed upon the compensation under this article; or unless, within two years after the death, one of the parties shall have filed a petition as provided in article four hereof. Where, however, in the case of any person receiving benefits pursuant to the act of June 28, 1935 (P.L. 477, No. 193), referred to as the Heart and Lung Act, the two-year period in which parties must agree upon the compensation or file a petition for compensation in cases of personal injury or in death, shall not begin to run until the expiration of the receipt of benefits pursuant to the Heart and Lung Act. Where, however, payments of compensation have been made in any case, said limitations shall not take effect until the expiration of two years from the time of the making of the most recent payment prior to date of filing such petition: Provided, That any payment made under an established plan or policy of insurance for the payment of benefits on account of nonoccupational illness or injury and which payment is identified as not being workmen's compensation shall not be considered to be payment in lieu of workmen's compensation, and such payment shall not toll the running of the Statute of Limitations. However, in cases of injury resulting from ionizing radiation in which the nature of the injury or its relationship to the employment is not known to the employe, the time for filing a claim shall not begin to run until the employe knows, or by the exercise of reasonable diligence should know, of the existence of the injury and its possible relationship to his employment. The term "injury" in this section means, in cases of occupational disease, disability resulting from occupational disease.

[Editor's Note: Text as amended by Act No. 56 of 1974.]

Sec 315 In cases of personal injury all claims for compensation shall be forever barred, unless, within three years after the injury, the parties shall have agreed upon the compensation payable under this article; or unless within three years after the injury, one of the parties shall have filed a petition as provided in article four hereof. In cases of death all claims for compensation shall be forever barred, unless within three years after the death, the parties shall have agreed upon the compensation under this article; or unless, within three years after the death, one of the parties shall have filed a petition as provided in article four hereof. Where, however, payments of compensation have been made in any case, said limitations shall not take effect until the expiration of three years from the time of the making of the most recent payment prior to date of filing such petition: Provided, That any payment made under an established plan or policy of insurance for the payment of benefits on account of non-occupational illness or injury and which payment is identified as not being workmen's compensation shall not be considered to be payment in lieu of workmen's compensation, and such payment shall not toll the running of the Statute of Limitations. However, in cases of injury resulting from ionizing radiation in which the nature of the injury or its relationship to the employment is not known to the employe, the time for filing a claim shall not begin to run until the employe knows, or by the exercise of reasonable diligence should know, of the existence of the injury and its possible relationship to his employment. The term "injury" in this section means, in cases of occupational disease, disability resulting from occupational disease.

[Editor's Note: Text as amended by Act No. 263 of 1974.]

Sec 316 The compensation contemplated by this article may at any time be commuted by the board, at its then value when discounted at five per centum interest, with annual rests, upon application of either party, with due notice to the other, if it appear that such commutation will be for the best interest of the employe or the dependents of the deceased employe, and that it will avoid undue expense or undue hardship to either party, or that such employe or dependent has removed or is about to remove from the United States, or that the employer has sold or otherwise disposed of the whole or the greater part of his business or assets: Provided, however, That unless the employer agrees to make such commutation, the

board may require the employe or the dependents of the deceased employe to furnish proper indemnity safeguarding the employer's rights. Nothing in this section shall prohibit, restrict or impair the right of the parties to enter into a compromise and release by stipulation in accord with section 449.

Sec 317 At any time after the approval of an agreement or after the entry of the award, a sum equal to all future installments of compensation may (where death or the nature of the injury renders the amount of future payments certain), with the approval of the board, be paid by the employer to any savings bank, trust company, or life insurance company, in good standing and authorized to do business in this Commonwealth, and such sum, together with all interest thereon, shall thereafter be held in trust for the employe or the dependents of the employe, who shall have no further recourse against the employer. The payment of such sum by the employer, evidenced by the receipt of the trustee noted upon the prothonotary's docket, shall operate as a satisfaction of said award as to the employer. Payments from said fund shall be made by the trustee in the same amounts and at the same periods as are herein required of the employer, until said fund and interest shall be exhausted. In the appointment of the trustee preference shall be given in the discretion of the board, to the choice of the employe or the dependents of the deceased employe. Should, however, there remain any unexpended balance of any fund after the payment of all sums due under this act, such balance shall be repaid to the employer who made the original payment, or to his legal representatives.

Sec 318 The right of compensation granted by this article of this act shall have the same preference (without limit of amount) against the assets of an employer, liable for such compensation, as is now or may hereafter be allowed by law for a claim for unpaid wages for labor: Provided, however, That no claim for compensation shall have priority over any judgment, mortgage, or conveyance of land recorded prior to the filing of the petition award, or agreement as to compensation in the office of the prothonotary of the county in which the land is situated. Claims for payments due under this article of this act and compensation payments made by virtue thereof shall not be assignable.

Sec 319 Where the compensable injury is caused in whole or in part by the act or omission of a third party, the employer shall be subrogated to the right of the employe, his personal representative, his estate or his dependents, against such third party to the extent of the compensation payable under this article by the employer; reasonable attorney's fees and other proper disbursements incurred in obtaining a recovery or in effecting a compromise settlement shall be prorated between the employer and employe, his personal representative, his estate or his dependents. The employer shall pay that proportion of the attorney's fees and other proper disbursements that the amount of compensation paid or payable at the time of recovery or settlement bears to the total recovery or settlement. Any recovery against such third person in excess of the compensation theretofore paid by the employer shall be paid forthwith to the employe, his personal representative, his estate or his dependents, and shall be treated as an advance payment by the employer on account of any future instalments of compensation.

Where an employe has received payments for the disability or medical expense resulting from an injury in the course of his employment paid by the employer or an insurance company on the basis that the injury and disability were not compensable under this act in the event of an agreement or award for that injury the employer or insurance company who made the payments shall be subrogated out of the agreement or award to the amount so paid, if the right to subrogation is agreed to by the parties or is established at the time of hearing before the referee or the board.

Sec 320 (a) If the employe at the time of the injury is a minor, under the age of eighteen years, employed or permitted to work in violation of any provision of the laws of this Commonwealth relating to minors of such age, compensation, either in the case of injury or death of such employe, shall be one hundred and fifty per centum of the amount that would be payable to such minor if legally employed. The amount by which such compensation shall exceed that provided for in case of legal employment may be referred to as "additional compensation."

(b) The employer and not the insurance carrier shall be liable for the additional compensation. Any provision in an insurance policy undertaking to relieve an employer from such liability shall be void.

- (c) Where death or the nature of the injury renders the amount of future payments certain, the total amount of the additional compensation, subject to discount as in the case of commutation, shall be immediately due and payable. It shall be deposited, subject to the approval of the board, in any savings bank, trust company, or life insurance company in good standing and authorized to do business in this Commonwealth.

Where the amount of the future payments of compensation is uncertain, the board shall, upon the approval of the agreement or the entry of an award, determine as nearly as may be the total amount of payment to be made, and the additional compensation so calculated shall, immediately upon such determination, become due and payable by the employer. The amount may be redetermined by the board and any increase shall then become due and payable, and any excess, which shall be shown to have been paid, shall be returned to the person paying the same. Upon determination of the amount due, it shall be deposited as above provided. Payments of compensation out of deposits shall be made to the employe or dependents as payments of other compensation are made: Provided, however, That the board may, in its discretion and upon inquiry as in cases of commutation, accelerate such payments.

- (d) The provisions of the foregoing paragraph (c) shall not apply to employers who are exempted by the department from the necessity of carrying insurance.
- (e) Possession of an employment certificate, duly issued and transmitted to the employer in accordance with the provisions of the child labor law and receipt thereof duly acknowledged by him, shall be conclusive evidence to such employer of his legal right to employ the minor for whose employment such certificate has been issued.
- (f) The possession of an age certificate, duly issued and transmitted to the employer by the school authorities of the school district in which a minor resides, shall be conclusive evidence to the employer of the minor's age as certified therein.
- (g) If neither party has elected not be bound by the provisions of article three of the act to which this act is an amendment, in the manner prescribed by section three hundred and two of said act, they shall be held to have agreed to be bound by the provisions of this act, and to have waived any other right or remedy at law or in equity, for the recovery of damages for injuries occurring under the circumstances herein described.

Sec 321 Nothing contained in this act shall apply to or in any way affect:

- (1) Any person who at the time of injury is engaged in domestic service: Provided, however, That in cases where the employer of any such person shall have, prior to such injury, by application to the department, and approved by the department, elected to come within the provisions of the act, such exemption shall not apply.
- (2) Any person who is a licensed real estate salesperson or an associate real estate broker affiliated with a licensed real estate broker or a licensed insurance agent affiliated with a licensed insurance agency, under a written agreement, remunerated on a commission-only basis and who qualifies as an independent contractor for State tax purposes or for Federal tax purposes under the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. §1 et seq.).

Sec 322 It shall be unlawful for any employe to receive compensation under this act if he is at the same time receiving workers' compensation under the laws of the Federal Government or any other state for the same injury. Further, it shall be unlawful for an employe receiving compensation under this act simultaneously from two or more employers or insurers during any period of total disability to receive total compensation in excess of the maximum benefit under this act. Nothing in this section shall be deemed to prohibit payment of workers' compensation on a pro-rata basis, where an employe suffers from more than one injury while in the employ of more than one employer: Provided, however, That the total

compensation paid shall not exceed the maximum weekly compensation payable under this act: And, Provided further, That any such pro rata calculation shall be based upon the earnings by such an employe in the employ of each such employer and that all wage losses suffered as a result of any injury which is compensable under this act shall be used as the basis for calculating the total compensation to be paid on a pro rata basis.

Sec 323

- (a) A construction design professional who is retained to perform professional services on a construction project or any employe of a construction design professional who is assisting or representing the construction design professional in the performance of professional services on the site of the construction project shall not be liable under this act for any injury or death of a worker not an employe of such design professional on the construction project for which workers' compensation is payable under the provisions of this act.
- (b) Notwithstanding any provisions to the contrary, this section shall apply to claims for compensation based on injuries or death which occurred after the effective date of this section.

ARTICLE IV Procedure

Sec 401 The term “referee,” when used in this act, shall mean a Workers’ Compensation Judge of the Department of Labor and Industry, appointed by and subject to the general supervision of the Secretary of Labor and Industry for the purpose of conducting departmental hearings under this act. The secretary may establish different classes of these judges. Any reference in any statute to a workmen’s compensation referee shall be deemed to be a reference to a workers’ compensation judge.

The term “board,” when used in this article, shall mean the Workers’ Compensation Appeal Board, a departmental administrative board as provided in sections 202, 207, 503 and 2208 of the act of April 9, 1929 (P.L. 177), known as “The Administrative Code of 1929,” exercising its powers and performing its duties as an appellate board independently of the Secretary of Labor and Industry and any other official of the department.

The term “fund,” when used in this article, shall mean the State Workmen’s Insurance Fund of the Commonwealth, the State-operated insurance carrier from which workmen’s compensation insurance policies may be purchased by employers to cover all risks of liability under this act including those declined by private carriers.

The terms “insurer” and “carrier,” when used in this article, shall mean the State Workmen’s Insurance Fund or other insurance carrier which has insured the employer’s liability under this act, or the employer in cases of self-insurance.

The term “employer,” when used in this article, shall mean the employer as defined in article one of this act, or his duly authorized agent, or his insurer if such insurer has assumed the employer’s liability or the fund if the employer be insured therein.

Sec 401.1 The department shall, in fulfillment of its responsibilities under this act, enforce the time standards and other performance standards herein provided for the prompt processing of injury cases and payment of compensation when due by employers and insurers both upon petition by a party or on its own motion. In any case in which compensation has not been timely paid, or in which notice of denial of compensation has been given, the department shall hear and determine all claim petitions for compensation filed by employes or their dependents. The department shall also hear and determine all petitions by employers or insurers to suspend, terminate, reduce or otherwise modify compensation payments, awards, or agreements and petitions by employes or their dependents to increase, modify or reinstate compensation payments, awards, or agreements. Hearings shall be scheduled forthwith upon receipt of the claim petition or other petition, as the case may be, and determinations thereon shall be made promptly and in conformity with time standards herein or hereunder established. Such hearings shall be conducted by a referee or other hearing officer designated by the secretary.

Delays in hearings will be granted according to rules established by the department, and any party who unreasonably delays a hearing will be subject to a penalty as provided in section 435. Subject to the provisions of the act of July 31, 1968 (Act No. 240), known as the “Commonwealth Documents Law,” the department shall adopt such rules and regulations as it finds necessary or desirable for the enforcement of this act.

Sec 402 All proceedings before any workers’ compensation judge, except those for which an informal conference has been applied for as provided by section 402.1, shall be instituted by claim petition or other petition as the case may be or on the department’s own motion, and all appeals to the board, shall be instituted by appeal addressed to the board. All claim petitions, requests for informal conferences and other petitions and appeals shall be in writing and in the form prescribed by the department.

Sec 402.1 (a) In any action for which a petition has been filed under this act, the parties by joint agreement may file a notice of request with the department for an informal conference pursuant to this act. The

department shall assign the matter to a workers' compensation judge or hearing officer for an informal conference. Unless the parties jointly agree to a time extension, all proceedings within an informal conference shall be completed within thirty-five days of the filing of the request for informal conference. Joint agreement to a time extension shall stay the adjudication proceedings for the time agreed upon.

- (b) At any informal conference held pursuant to this section:
 - (i) the workers' compensation judge or hearing officer may accept the statements of both parties, together with any medical reports, witnesses' statements or other documents which the parties would like to present;
 - (ii) all communications, verbal or written, from the parties to the workers' compensation judge or hearing officer and any information and evidence presented to the workers' compensation judge or hearing officer during the informal conference proceedings are confidential and shall not be a part of the record of testimony; and
 - (iii) each party may be represented, but the employer may only be represented by an attorney at the informal conference if the employer is also represented by an attorney at the informal conference.
- (c) The workers' compensation judge or hearing officer shall attempt to resolve the issues in dispute between the parties, but in no event shall any recommendations or findings made by the workers' compensation judge or hearing officer be binding upon the parties unless accepted in writing by both parties. If the parties come to agreement, the workers' compensation judge or hearing officer shall reduce such agreement to writing, which shall be signed by all parties and filed with the department.
- (d) In the event that the parties cannot resolve their dispute, the petition will be reassigned to a different workers' compensation judge for adjudication of the dispute, or, by joint agreement of the parties, the workers' compensation judge who was originally assigned the matter will proceed with the adjudication of the petition.
- (e) The information provided at the informal conference does not constitute established evidence for any subsequent proceeding on the petition.
- (f) No workers' compensation judge or hearing officer who participates in an informal conference conducted pursuant to this section shall be compelled or permitted to testify about any matter discussed or revealed during such proceedings in any other proceeding pursuant to this act, except matters involving fraud.

Sec 403 All petitions, all copies of notices of compensation payable and agreements for compensation, and all papers requiring action by the department and its referees or the board, shall be mailed or delivered to the department at its principal office.

Sec 404 The department shall, immediately upon their receipt, properly file and docket all claim petitions and other petitions, notices of compensation payable, agreements for compensation, findings of fact, awards or disallowances of compensation, or modifications thereof, and all other decisions, reports or papers filed with it under the provisions of this act or the rules and regulations of the department or the board.

Sec 405 Immediately upon making or receiving any award or disallowance of compensation, or any modification thereof, or any other decision, the department shall serve a copy thereof on all parties in interest.

Sec 406 All notices and copies to which any parties shall be entitled under the provisions of this article shall be served by mail, or in such manner as the department shall direct. For the purposes of this article any

notice or copy shall be deemed served on the date when mailed, properly stamped and addressed, and shall be presumed to have reached the party to be served; but any party may show by competent evidence that any notice or copy was not received, or that there was an unusual or unreasonable delay in its transmission through the mails. In any such case proper allowance shall be made for the party's failure within the prescribed time to assert any right given him by this act.

The department, the secretary of the board, and every referee shall keep a careful record of the date of mailing every notice and copy required by this act to be served on the parties in interest.

- Sec 406.1
- (a) The employer and insurer shall promptly investigate each injury reported or known to the employer and shall proceed promptly to commence the payment of compensation due either pursuant to an agreement upon the compensation payable or a notice of compensation payable as provided in section 407 or pursuant to a notice of temporary compensation payable as set forth in subsection (d), on forms prescribed by the department and furnished by the insurer. The first installment of compensation shall be paid not later than the twenty-first day after the employer has notice or knowledge of the employee's disability. Interest shall accrue on all due and unpaid compensation at the rate of ten per centum per annum. Any payment of compensation prior or subsequent to an agreement or notice of compensation payable or a notice of temporary compensation payable or greater in amount than provided therein shall, to the extent of the amount of such payment or payments, discharge the liability of the employer with respect to such case.
 - (b) Payments of compensation pursuant to an agreement or notice of compensation payable may be suspended, terminated, reduced or otherwise modified by petition and subject to right of hearing as provided in section 413.
 - (c) If the insurer controverts the right to compensation it shall promptly notify the employee or his dependent, on a form prescribed by the department, stating the grounds upon which the right to compensation is controverted and shall forthwith furnish a copy or copies to the department.
 - (d)
 - (1) In any instance where an employer is uncertain whether a claim is compensable under this act or is uncertain of the extent of its liability under this act, the employer may initiate compensation payments without prejudice and without admitting liability pursuant to a notice of temporary compensation payable as prescribed by the department.
 - (2) The notice of temporary compensation payable shall be sent to the claimant and a copy filed with the department and shall notify the claimant that the payment of temporary compensation is not an admission of liability of the employer with respect to the injury which is the subject of the notice of temporary compensation payable. The department shall, upon receipt of a notice of temporary compensation payable, send a notice to the claimant informing the claimant that:
 - (i) the payment of temporary compensation and the claimant's acceptance of that compensation does not mean the claimant's employer is accepting responsibility for the injury or that a compensation claim has been filed or commenced;
 - (ii) the payment of temporary compensation entitles the claimant to a maximum of ninety (90) days of compensation; and
 - (iii) the claimant may need to file a claim petition in a timely fashion under section 315, enter into an agreement with his employer or receive a notice of compensation payable from his employer to ensure continuation of compensation payments.
 - (3) Payments of temporary compensation shall commence and the notice of temporary compensation payable shall be sent within the time set forth in clause (a).

- (4) Payments of temporary compensation may continue until such time as the employer decides to controvert the claim.
- (5)
 - (i) If the employer ceases making payments pursuant to a notice of temporary compensation payable, a notice in the form prescribed by the department shall be sent to the claimant and a copy filed with the department, but in no event shall this notice be sent or filed later than five (5) days after the last payment.
 - (ii) This notice shall advise the claimant, that if the employer is ceasing payment of temporary compensation, that the payment of temporary compensation was not an admission of liability of the employer with respect to the injury subject to the notice of temporary compensation payable, and the employe must file a claim to establish the liability of the employer.
 - (iii) If the employer ceases making payments pursuant to a notice of temporary compensation payable, after complying with this clause, the employer and employe retain all the rights, defenses and obligations with regard to the claim subject to the notice of temporary compensation payable, and the payment of temporary compensation may not be used to support a claim for compensation.
 - (iv) Payment of temporary compensation shall be considered compensation for purposes of tolling the statute of limitations under section 315.
- (6) If the employer does not file a notice under paragraph (5) within the ninety-day period during which temporary compensation is paid or payable, the employer shall be deemed to have admitted liability and the notice of temporary compensation payable shall be converted to a notice of compensation payable.

Sec 407

On or after the seventh day after any injury shall have occurred, the employer or insurer and employe or his dependents may agree upon the compensation payable to the employe or his dependents under this act; but any agreement made prior to the seventh day after the injury shall have occurred, or permitting a commutation of payments contrary to the provisions of this act, or varying the amount to be paid or the period during which compensation shall be payable as provided in this act, shall be wholly null and void. It shall be unlawful for any employer to accept a receipt showing the payment of compensation when in fact no such payment has been made.

Where payment of compensation is commenced without an agreement, the employer or insurer shall simultaneously give notice of compensation payable to the employe or his dependent, on a form prescribed by the department, identifying such payments as compensation under this act and shall forthwith furnish a copy or copies to the department as required by rules and regulations. It shall be the duty of the department to examine the notice to determine whether it conforms to the provisions of this act and rules and regulations hereunder.

All agreements made in accordance with the provisions of this section shall be on a form prescribed by the department, signed by all parties in interest, and a copy or copies thereof forwarded to the department as required by rules and regulations. It shall be the duty of the department to examine the agreement to determine whether it conforms to the provisions of this act and rules and regulations hereunder.

All notices of compensation payable and agreements for compensation and all supplemental agreements for the modification, suspension, reinstatement, or termination thereof, and all receipts executed by any injured employe of whatever age, or by any dependent to whom compensation is payable under section three hundred and seven, and who has attained the age of sixteen years, shall be valid and binding unless modified or set aside as hereinafter provided.

Sec 408

All notices of compensation payable and agreements for compensation may be modified, suspended,

reinstated, or terminated at any time by an agreement or supplemental agreement as the case may be with notice to the department, if the incapacity of an injured employe has increased, decreased, recurred, or temporarily or finally terminated, or if the status of any dependent has changed.

Sec 409 Whenever an agreement or supplemental agreement shall be executed between an employer or his insurer and an employe or his dependents as provided by this act, such agreement shall be executed in triplicate. It shall be the duty of the department to examine the agreement to determine whether it conforms to the provisions of this act and rules and regulations hereunder. The employer or the insurer as the case may be shall immediately furnish one copy of the agreement to the employe or his dependents and forward another copy or copies to the department as required by rules and regulations. If compensation payments have not already been made, compensation shall be commenced forthwith upon execution of the agreement.

Sec 410 If, after any injury, the employer or his insurer and the employe or his dependent, concerned in any injury, shall fail to agree upon the facts thereof or the compensation due under this act, the employe or his dependents may present a claim petition for compensation to the department.

In case any claimant shall die before the final adjudication of his claim, the amount of compensation due such claimant to the date of death shall be paid to the dependents entitled to compensation, or, if there be no dependents, then to the estate of the decedent.

Whenever any claim for compensation is presented and the only issue involved is the liability as between the defendant or the carrier or two or more defendants or carriers, the referee of the department to whom the claim in such case is presented shall forthwith order payments to be immediately made by the defendants or the carriers in said case. After the department's referee or the board on appeal, render a final decision, the payments made by the defendant or carrier not liable in the case shall be awarded or assessed against the defendant or carrier liable in the case, as costs in the proceedings, in favor of the defendant or carrier not liable in the case.

Sec 411 Whenever the employer or his insurer and the employe or his dependent shall, on or after the seventh day after any injury, agree on all of the facts on which a claim for compensation depends, but shall fail to agree on the compensation payable, they may petition the department to determine the compensation payable. Such petition shall contain the agreed facts, and shall be signed by all parties in interest. The department or its referee shall fix a time and place for hearing the petition, and shall notify all parties in interest. As soon as may be after such hearing, the department or its referee shall award or disallow compensation in accordance with the provisions of this act.

Sec 412 If any party shall desire the commutation of future installments of compensation, he shall present a petition therefor to the department to be heard and determined by a workers' compensation judge: Provided, That where there are no more than fifty-two weeks of compensation to be commuted, the insurer or self-insurer may commute such future installments without discount upon furnishing the employe written notice of the commutation on a form prescribed by the department, a copy of which shall be filed immediately with the department. Nothing in this section shall prohibit, restrict or impair the right of the parties to enter into a compromise and release by stipulation in accord with section 449.

Sec 413 (a) A workers' compensation judge of the department may, at any time, review and modify or set aside a notice of compensation payable and an original or supplemental agreement or upon petition filed by either party with the department, or in the course of the proceedings under any petition pending before such workers' compensation judge, if it be proved that such notice of compensation payable or agreement was in any material respect incorrect.

A workers' compensation judge designated by the department may, at any time, modify, reinstate, suspend, or terminate a notice of compensation payable, an original or supplemental agreement or an award of the department or its workers' compensation judge, upon petition filed by either party with the department, upon proof that the disability of an injured employe has increased, decreased,

recurred, or has temporarily or finally ceased, or that the status of any dependent has changed. Such modification, reinstatement, suspension, or termination shall be made as of the date upon which it is shown that the disability of the injured employe has increased, decreased, recurred, or has temporarily or finally ceased, or upon which it is shown that the status of any dependent has changed: Provided, That, except in the case of eye injuries, no notice of compensation payable, agreement or award shall be reviewed, or modified, or reinstated, unless a petition is filed with the department within three years after the date of the most recent payment of compensation made prior to the filing of such petition. Where, however, a person is receiving benefits pursuant to the act of June 28, 1935 (P.L. 477, No. 193), referred to as the Heart and Lung Act, the two-year period in which a petition to review, modify, or reinstate a notice of compensation, agreement or award must be filed, shall not begin to run until the expiration of the receipt of benefits pursuant to the Heart and Lung Act: And provided further, That any payment made under an established plan or policy of insurance for the payment of benefits on account of nonoccupational illness or injury and which payment is identified as not being workmen's compensation shall not be considered to be payment in lieu of workmen's compensation, and such payment shall not toll the running of the Statute of Limitations: And provided further, That where compensation has been suspended because the employe's earnings are equal to or in excess of his wages prior to the injury that payments under the agreement or award may be resumed at any time during the period for which compensation for partial disability is payable, unless it be shown that the loss in earnings does not result from the disability due to the injury.

The workers' compensation judge to whom any such petition has been assigned may subpoena witnesses, hear evidence, make findings of fact, and award or disallow compensation, in the same manner and with the same effect and subject to the same right of appeal, as if such petition were an original claim petition.

- (a.1) The filing of a petition to terminate, suspend or modify a notice of compensation payable or a compensation agreement or award as provided in this section shall automatically operate as a request for a supersedeas to suspend the payment of compensation fixed in the agreement or the award where the petition alleges that the employe has fully recovered and is accompanied by an affidavit of a physician on a form prescribed by the department to that effect, which is based upon an examination made within twenty-one days of the filing of the petition. A special supersedeas hearing before a workers' compensation judge shall be held within twenty-one days of the assignment of such petition. All parties to the special supersedeas hearing shall have the right to submit, and the workers' compensation judge may consider testimony of any party or witness; the record of any physician; the records of any physician, hospital, clinic or similar entity; the written statements or reports of any other person expected to be called by any party at the hearing of the case; and any other relevant materials. The workers' compensation judge shall rule on the request for supersedeas within seven days of the hearing and shall approve the request if prima facie evidence of a change in the medical status or of any other fact which would serve to modify or terminate payment of compensation is submitted at the hearing, unless the employe establishes, by a preponderance of the evidence, a likelihood of prevailing on the merits of his defense. The workers' compensation judge's decision on supersedeas shall be interlocutory and shall not be appealable. The determination of full recovery with respect to either the petition to terminate or modify or the request for supersedeas shall be made without consideration of whether a specific job vacancy exists for the employe for work which the employe is capable of performing or whether the employe would be hired if the employe applied for work which the employe is capable of performing.
- (a.2) In any other case, a petition to terminate, suspend or modify a compensation agreement or other payment arrangement or award as provided in this section shall not automatically operate as a supersedeas but may be designated as a request for a supersedeas, which may then be granted at the discretion of the workers' compensation judge hearing the case. A supersedeas shall serve to suspend the payment of compensation in whole or to such extent as the facts alleged in the petition would, if proved, require. The workers' compensation judge hearing the case shall rule on the

request for a supersedeas as soon as possible and may approve the request if proof of a change in medical status, or proof of any other fact which would serve to modify or terminate payment of compensation is submitted with the petition. The workers' compensation judge hearing the case may consider any other fact which he deems to be relevant when making the decision on the supersedeas request and the decision shall not be appealable.

- (b) Any insurer who suspends, terminates or decreases payments of compensation without submitting an agreement or supplemental agreement therefor as provided in section 408, or a final receipt as provided in section 434, or without filing a petition and either alleging that the employe has returned to work at his prior or increased earnings or where the petition alleges that the employe has fully recovered and is accompanied by an affidavit of a physician on a form prescribed by the department to that effect which is based upon an examination made within twenty-one days of the filing of the petition or having requested and been granted a supersedeas as provided in this section, shall be subject to penalty as provided in section 435.
- (c) Notwithstanding any provision of this act, an insurer may suspend the compensation during the time the employe has returned to work at his prior or increased earnings upon written notification of suspension by the insurer to the employe and the department, on a form prescribed by the department for this purpose. The notification of suspension shall include an affidavit by the insurer that compensation has been suspended because the employe has returned to work at prior or increased earnings. The insurer must mail the notification of suspension to the employe and the department within seven days of the insurer suspending compensation.
 - (1) If the employe contests the averments of the insurer's affidavit, a special supersedeas hearing before a workers' compensation judge may be requested by the employe indicating by a checkoff on the notification form that the suspension of benefits is being challenged and filing the notification of challenge with the department within twenty days of receipt of the notification of suspension from the insurer. The special supersedeas hearing shall be held within twenty-one days of the employe's filing of the notification of challenge.
 - (2) If the employe does not challenge the insurer's notification of suspension within twenty days under paragraph (1), the employe shall be deemed to have admitted to the return to work and receipt of wages at prior or increased earnings. The insurer's notification of suspension shall be deemed to have the same binding effect as a fully executed supplemental agreement for the suspension of benefits.
- (d) Notwithstanding any provision of this act, an insurer may modify the compensation payments made during the time the employe has returned to work at earnings less than the employe earned at the time of the work-related injury, upon written notification of modification by the insurer to the employe and the department, on a form prescribed by the department for this purpose. The notification of modification shall include an affidavit by the insurer that compensation has been modified because the employe has returned to work at lesser earnings. The insurer must mail the notification of modification to the employe and the department within seven days of the insurer's modifying compensation.
 - (1) If the employe contests the averments of the insurer's affidavit, a special supersedeas hearing before a workers' compensation judge may be requested by the employe indicating by a checkoff on the notification form that the modification of benefits is being challenged and filing the notification of challenge with the department within twenty days of receipt of the notification of modification from the insurer. The special supersedeas hearing shall be held within twenty-one days of the employe's filing of the notification of challenge.
 - (2) If the employe does not challenge the insurer's notification of modification within twenty days under paragraph (1), the employe shall be deemed to have admitted to the return to work and receipt of wages at lesser earnings as alleged by the insurer. The insurer's notifi-

cation of modification shall be deemed to have the same binding effect as a fully executed supplemental agreement for the modification of benefits.

Sec 414 Whenever a claim petition or other petition is presented to the department, the department shall, by general rules or special order, assign it to a referee for hearing.

The department shall serve upon each adverse party a copy of the petition, together with a notice that such petition will be heard by the referee to whom it has been assigned (giving his name and address) as the case may be, and shall mail the original petition to such referee, together with copies of the notices served upon the adverse parties.

Sec 415 At any time before an award or disallowance of compensation or order has been made by a referee to whom a petition has been assigned, the department may order such petition heard before any other referee. Unless the department shall otherwise order, the testimony taken before the original referee shall be considered as though taken before the substituted referee.

Sec 416 Within twenty days after a copy of any claim petition or other petition has been served upon an adverse party, he may file with the department or its workers' compensation judge an answer in the form prescribed by the department.

Every fact alleged in a claim petition not specifically denied by an answer so filed by any adverse party shall be deemed to be admitted by him. But the failure of any party or of all of them to deny a fact alleged in any other petition shall not preclude the workers' compensation judge before whom the petition is heard from requiring, of his own motion, proof of such fact. If a party fails to file an answer and/or fails to appear in person or by counsel at the hearing without adequate excuse, the workers' compensation judge hearing the petition shall decide the matter on the basis of the petition and evidence presented.

Sec 417 Within fifteen days after notice that a petition has been directed to be heard by a referee has been served upon the adverse parties thereof, the referee shall fix a time and place for hearing the petition. The referee shall as soon as practicable within the limitations prescribed herein fix a time and a place for hearing the petition and serve upon all parties in interest a notice of the time and place of hearing, and shall serve upon the petitioner a copy of any answer of any adverse party. The hearing on any such petition shall be held within thirty-five days of the filing of the petition.

Sec 418 The referee to whom a petition is assigned for hearing, may subpoena witnesses, order the production of books and other writings, and hear evidence, shall make a record of hearings, and shall make, in writing and as soon as may be after the conclusion of the hearing, such findings of fact, conclusions of law, and award or disallowance of compensation or other order, as the petition and answers and the evidence produced before him and the provisions of this act shall, in his judgment, require. The findings of fact made by a referee to whom a petition has been assigned or any question of fact has been referred under the provisions of section four hundred and nineteen shall be final, unless an appeal is taken as provided in this act.

Sec 419 The board may remand any case involving any question of fact arising under any appeal to a referee to hear evidence and report to the board the testimony taken before him or such testimony and findings of fact thereon as the board may order. The department may refer any question of fact arising out of any petition assigned to a referee, to any other referee to hear evidence, and report the testimony so taken thereon to the original referee.

Sec 420 (a) The board, the department or a workers' compensation judge, if it or he deem it necessary, may, of its or his own motion, either before, during, or after any hearing, make or cause to be made an investigation of the facts set forth in the petition or answer or facts pertinent in any injury under this act. The board, department or workers' compensation judge may appoint one or more impartial physicians or surgeons to examine the injuries of the plaintiff and report thereon, or may

employ the services of such other experts as shall appear necessary to ascertain the facts. The workers' compensation judge when necessary or appropriate or upon request of a party in order to rule on requests for review filed under section 306(f.1), or under other provisions of this act, may ask for an opinion from peer review about the necessity or frequency of treatment under section 306(f.1). The peer review report or the peer report of any physician, surgeon, or expert appointed by the department or by a workers' compensation judge, including the report of a peer review organization, shall be filed with the board or workers' compensation judge, as the case may be, and shall be a part of the record and open to inspection as such. The workers' compensation judge shall consider the report as evidence but shall not be bound by such report.

- (b) The board or workers' compensation judge, as the case may be, shall fix the compensation of such physicians, surgeons, and experts, and other peer review organizations which, when so fixed, shall be paid out of the Workmen's Compensation Administration Fund.

Sec 421 All hearings before the board, or one or more members thereof, or before a referee shall be public.

Sec 422 (a) Neither the board nor any of its members nor any workers' compensation judge shall be bound by the common law or statutory rules of evidence in conducting any hearing or investigation, but all findings of fact shall be based upon sufficient competent evidence to justify same. All parties to an adjudicatory proceeding are entitled to a reasoned decision containing findings of fact and conclusions of law based upon the evidence as a whole which clearly and concisely states and explains the rationale for the decisions so that all can determine why and how a particular result was reached. The workers' compensation judge shall specify the evidence upon which the workers' compensation judge relies and state the reasons for accepting it in conformity with this section. When faced with conflicting evidence, the workers' compensation judge must adequately explain the reasons for rejecting or discrediting competent evidence. Uncontroverted evidence may not be rejected for no reason or for an irrational reason; the workers' compensation judge must identify that evidence and explain adequately the reasons for its rejection. The adjudication shall provide the basis for meaningful appellate review.

- (b) If any party or witness resides outside of the Commonwealth, or through illness or other cause is unable to testify before the board or a workers' compensation judge, his or her testimony or deposition may be taken, within or without this Commonwealth, in such manner and in such form as the department may, by special order or general rule, prescribe. The records kept by a hospital of the medical or surgical treatment given to an employe in such hospital shall be admissible as evidence of the medical and surgical matters stated therein.

- (c) Where any claim for compensation at issue before a workers' compensation judge involves fifty-two weeks or less of disability, either the employe or the employer may submit a certificate by any health care provider as to the history, examination, treatment, diagnosis, cause of the condition and extent of disability, if any, sworn reports by other witnesses as to any other facts and such statements shall be admissible as evidence of medical and surgical or other matters therein stated and findings of fact may be based upon such certificates or such reports. Where any claim for compensation at issue before a workers' compensation judge exceeds fifty-two weeks of disability, a medical report shall be admissible as evidence unless the party that the report is offered against objects to its admission.

- (d) Where an employer shall have furnished surgical and medical services or hospitalization in accordance with the provisions of section 306(f.1), or where the employe has himself procured them, the employer or employe shall, upon request, in any pending proceeding, be furnished with, or have made available, a true and complete record of the medical and surgical services and hospital treatment, including X rays, laboratory tests, and all other medical and surgical data in the possession or under the control of the party requested to furnish or make available such data.

- (e) The department may adopt rules and regulations governing the conduct of all hearings held pursu-

ant to any provisions of this act, and hearings shall be conducted in accordance therewith, and in such manner as best to ascertain the substantial rights of the parties.

- Sec 423 (a) Any party in interest may, within twenty days after notice of a workers' compensation judge adjudication shall have been served upon him, take an appeal to the board on the ground: (1) that the adjudication is not in conformity with the terms of this act, or that the workers' compensation judge committed any other error of law; (2) that the findings of fact and adjudication was unwarranted by sufficient, competent evidence or was procured by fraud, coercion, or other improper conduct of any party in interest. The board may, upon cause shown, extend the time provided in this article for taking such appeal or for the filing of an answer or other pleading.
- (b) If a timely appeal is filed by a party in interest pursuant to clause (a), any other party may file a cross-appeal within fourteen days of the date on which the first appeal was filed or within the time prescribed by clause (a), whichever period last expires.
- (c) The board shall hear the appeal on the record certified by the workers' compensation judge's office. The board shall affirm the workers' compensation judge adjudication, unless it shall find that the adjudication is not in compliance with section 422(a) and the other provisions of this act.

Sec 424 Whenever an appeal shall be based upon an alleged error of law, it shall be the duty of the board to grant a hearing thereon. The board shall fix a time and place for such hearing, and shall serve notice thereof on all parties in interest.

As soon as may be after such hearing, the board shall either sustain or reverse the referee's award or disallowance of compensation, or make such modification thereof as it shall deem proper.

Sec 425 If on appeal it appears that the referee's award or disallowance of compensation was capricious or caused by fraud, coercion, or other improper conduct by any party in interest, the board may, grant a hearing de novo before the board, or one or more of its members or remand the case for rehearing to any referee. If the board shall grant a hearing de novo, it shall fix a time and place for same, and shall notify all parties in interest.

As soon as may be after any hearing by the board, it shall in writing state the findings of fact, whether those of the referee or its own, which are basic to its decision and award or disallow compensation in accordance with the provisions of this act.

Sec 426 The board, upon petition of any party and upon cause shown, may grant a rehearing of any petition upon which the board has made an award or disallowance of compensation or other order or ruling, or upon which the board has sustained or reversed any action of a referee; but such rehearing shall not be granted more than eighteen months after the board has made such award, disallowance, or other order or ruling, or has sustained or reversed any action of the referee. Provided, however, That nothing contained in this section shall limit or restrict the right of the board, or a referee to review, modify, set aside, reinstate, suspend, or terminate, an original or supplemental agreement, or an award in accordance with the provisions of section four hundred thirteen of this article.

[Editor's Note: See "Additional Relevant Statutory Provisions," Appendix C, (1).]

Sec 427 Repealed.

Sec 428 Whenever the employer, who has accepted and complied with the provisions of section three hundred five, shall be in default in compensation payments for thirty days or more, the employe or dependents entitled to compensation thereunder may file a certified copy of the agreement and the order of the department approving the same or of the award or order with the prothonotary of the court of common pleas of any county, and the prothonotary shall enter the entire balance payable under the agreement, award or order to be payable to the employe or his dependents, as a judgment against the employer or

insurer liable under such agreement or award. Where the compensation so payable is for a total and permanent disability, the judgment shall be in the amount of thirty thousand dollars less such amount as the employer shall have actually paid pursuant to such agreement or award. Such judgment shall be a lien against property of the employer or insurer liable under such agreement or award and execution may issue thereon forthwith.

Whenever, after an injury, any employe or his dependents shall have entered into a compensation agreement with an employer, who has not accepted or complied with the provisions of section three hundred five, or shall file a claim petition against such employer, he may file a certified copy thereof with the prothonotary of the court of common pleas of any county. The prothonotary shall enter the amount stipulated in any such agreement or claimed in any such claim petition as judgment against the employer, and where the amount so stipulated or claimed is for total and permanent disability, such judgment shall be in the sum of thirty thousand dollars. If the agreement be approved by the department, or compensation awarded as claimed in the petition, the amount of compensation stipulated in the agreement or claimed in the petition shall be a lien, as of the date when the agreement or petition was filed with the prothonotary. Pending the approval of the agreement or the award of compensation, no other lien which may be attached to the employer's property during such time shall gain priority over the lien of such agreement or award; but no execution shall issue on any compensation judgment before the approval of the agreement or the award of compensation on the said petition.

If the agreement be disapproved, or, after hearing, compensation shall be disallowed, the employer may file, with the prothonotary of any county in which the petition or agreement is on record as a judgment, a certified copy of the disapproval of the agreement or disallowance of compensation, and it shall be the duty of such prothonotary to strike off the judgment.

If the amount of compensation claimed be disallowed, but another amount awarded, the compensation judgment shall be a lien to the extent of the award, as of the date of filing the petition with the prothonotary, with the same effect as to other liens and the same disability to issue execution thereon as if the compensation claimed had been allowed. In such cases the prothonotary shall make such modification of the record as shall be appropriate.

If the compensation payable under any agreement or award upon which judgment has been entered under the provisions of this section shall be modified, suspended, reinstated, or terminated by a supplemental agreement executed under the provisions of section four hundred and eight, or by an award or order made under the provisions of section four hundred and thirteen, any party to such judgment, at any time after such agreement has been approved by the department or after the expiration of the time allowed for an appeal from the award or order, may file with the prothonotary of the court of common pleas of any county in which the judgment is on record a certified copy of such supplemental agreement, award, or order and it shall thereupon be the duty of the prothonotary to modify, suspend, reinstate, or satisfy such judgment in accordance with the terms of such supplemental agreement, award, or order.

Execution may issue by first filing with the prothonotary an affidavit that there has been a default in payments of compensation due on any judgment for compensation, entered prior to the approval of the compensation agreement, or an award on petition, as soon as such agreement shall have been approved by the department or such award made as evidenced by the approval of the board of the award or by a certified copy thereof.

Execution shall in all cases be for the amount of compensation and interest thereon due and payable up to the date of the issuance of said execution, with costs, and further execution may issue from time to time as further compensation shall become due and payable until full amount of the judgment with costs shall have actually been paid.

Sec 429

If any party against whom a compensation agreement, award, or other order fixing the compensation payable under this act has been filed of record in any county of this Commonwealth in accordance with the provisions of section four hundred and twenty-eight of this article, or against whom judgment has

been entered by the prothonotary of the court of common pleas of any county on any award or order of the board or a referee, shall, at any time, present to the department receipts or copies thereof, certified by any referee, showing the payment of compensation as required by the agreement or award in full to the date of presentation to the referee, the department shall issue a certificate to such party, in the form prescribed, stating the extent to which the judgment on the agreement or award has been reduced. Upon the presentation of such certificate to the prothonotary of the court of common pleas of any county in which such agreement or award has been filed of record as a judgment, or in which judgment on an award has been entered by the prothonotary of the court of common pleas, it shall be the prothonotary's duty to mark such judgment satisfied to the extent of the payments so certified, and, upon the presentation to such prothonotary of a certificate issued by the board under the provisions of section three hundred and seventeen of this act, it shall be the duty of the prothonotary to mark such judgment fully satisfied.

- Sec 430 (a) The lien of any judgment entered upon any award shall not be divested by any appeal.
- (b) Any insurer or employer who terminates, decreases or refuses to make any payment provided for in the decision without filing a petition and being granted a supersedeas shall be subject to a penalty as provided in section 435, except in the case of payments terminated as provided in section 434.
- Sec 431 The cost of the prothonotary for entering the amount of compensation as provided in this act, or making a modification of the record, or marking the judgment satisfied, shall be allowed, taxed, and collected as upon a confession of judgment on a judgment note.
- Sec 432 Repealed.
- Sec 433 Repealed.
- Sec 434 A final receipt, given by an employe or dependent entitled to compensation under a compensation agreement notice or award, shall be prima facie evidence of the termination of the employer's liability to pay compensation under such agreement notice or award: Provided, however, That a referee designated by the department may, at any time within three years from the date to which payments have been made, set aside a final receipt, upon petition filed with the department, or on the department's own motion, if it be shown that all disability due to the injury in fact had not terminated. Where, however, a person is receiving benefits pursuant to the act of June 28, 1935 (P.L. 477, No. 193), referred to as the Heart and Lung Act, the two-year period within which a referee may set aside a final receipt upon petition filed with the department, or upon the department's own motion, shall not begin to run until the expiration of the receipt of benefits pursuant to the Heart and Lung Act.
- Sec 435 (a) The department shall establish and promulgate rules and regulations consistent with this act, which are reasonably calculated to:
- (i) expedite the reporting and processing injury cases,
 - (ii) insure full payment of compensation when due,
 - (iii) expedite the hearing and determination of claims for compensation and petitions filed with the department under this act,
 - (iv) provide the disabled employe or his dependents with timely notice and information of his or their rights under this act,
 - (v) explain and enforce the provisions of this act.
- (b) If it appears that there has not been compliance with this act or rules and regulations promulgated

thereunder the department may, on its own motion give notice to any persons involved in such apparent noncompliance and schedule a hearing for the purpose of determining whether there has been compliance. The notice of hearing shall contain a statement of the matter to be considered.

- (c) The board shall establish rules of procedure, consistent with this act, which are reasonably calculated to expedite the hearing and determination of appeals to the board and to insure full payment of compensation when due.
- (d) The department, the board, or any court which may hear any proceedings brought under this act shall have the power to impose penalties as provided herein for violations of the provisions of this act or such rules and regulations or rules of procedure:
 - (i) Employers and insurers may be penalized a sum not exceeding ten per centum of the amount awarded and interest accrued and payable: Provided, however, That such penalty may be increased to fifty per centum in cases of unreasonable or excessive delays. Such penalty shall be payable to the same persons to whom the compensation is payable.
 - (ii) Any penalty or interest provided for anywhere in this act shall not be considered as compensation for the purposes of any limitation on the total amount of compensation payable which is set forth in this act.
 - (iii) Claimants shall forfeit any interest that would normally be payable to them with respect to any period of unexcused delay which they have caused.
- (e) The department shall furnish to persons adversely affected by occupational disease appropriate counseling services, vocational rehabilitation services, and other supportive services designed to promote employability to the extent that such services are available and practical.

Sec 436 The secretary, any referee, and any member of the board shall have the power to issue subpoenas to require the attendance of witnesses and/or the production of books, documents, and papers pertinent to any hearing. Any witness who refuses to obey such summons or subpoenas, or who refuses to be sworn or affirmed to testify, or who is guilty of any contempt after notice to appear, may be punished as for contempt of court, and, for this purpose, an application may be made to any court of common pleas within whose territorial jurisdiction the offense was committed, for which purpose such court is hereby given jurisdiction.

Sec 437 The board, department and any referee shall have the power to conduct any investigation which may be deemed necessary in any matter properly before them. Such investigations may be made by the board or referee personally, or by any officer or employe of the department, or by any inspector of the department, or by any person or persons authorized by law. Every inspector and employe of the department is hereby empowered and directed to conduct any investigation authorized by this act, at the request of the board, department or any referee, with the consent of the secretary.

Sec 438 (a) An employer shall report all injuries received by employes in the course of or resulting from their employment immediately to the employer's insurer. If the employer is self-insured such injuries shall be reported to the person responsible for management of the employer's compensation program.

(b) An employer shall report such injuries to the Department of Labor and Industry by filing directly with the department on the form it prescribes a report of injury within forty-eight hours for every injury resulting in death, and mailing within seven days after the date of injury for all other injuries except those resulting in disability continuing less than the day, shift, or turn in which the injury was received. A copy of this report to the department shall be mailed to the employer's insurer forthwith.

- (c) Reports of injuries filed with the department under this section shall not be evidence against the employer or the employer's insurer in any proceeding either under this act or otherwise. Such reports may be made available by the department to other State or Federal agencies for study or informational purposes.

Sec 439 Every employer shall keep a record of each injury to any of his employes as reported to him or of which he otherwise has knowledge. Such record shall include a description of the injury, a statement of any time during which the injured person was unable to work because of the injury, and a description of the manner in which the injury occurred. These records shall be available for inspection by the department or by any governmental agency at reasonable times.

Sec 440 (a) In any contested case where the insurer has contested liability in whole or in part, including contested cases involving petitions to terminate, reinstate, increase, reduce or otherwise modify compensation awards, agreements or other payment arrangements or to set aside final receipts, the employe or his dependent, as the case may be, in whose favor the matter at issue has been finally determined in whole or in part shall be awarded, in addition to the award for compensation, a reasonable sum for costs incurred for attorney's fee, witnesses, necessary medical examination, and the value of unreimbursed lost time to attend the proceedings: Provided, That cost for attorney fees may be excluded when a reasonable basis for the contest has been established by the employer or the insurer.

- (b) If counsel fees are awarded and assessed against the insurer or employer, then the workers' compensation judge must make a finding as to the amount and the length of time for which such counsel fee is payable based upon the complexity of the factual and legal issues involved, the skill required, the duration of the proceedings and the time and effort required and actually expended. If the insurer has paid or tendered payment of compensation and the controversy relates to the amount of compensation due, costs for attorney's fee shall be based only on the difference between the final award of compensation and the compensation paid or tendered by the insurer.

Sec 441 (a) If any insurer licensed to transact the business of workmen's compensation insurance within this Commonwealth repeatedly or unreasonably fails to pay promptly compensation for which it is liable or fails or refuses to submit any report or to pay any assessment made under this act, the secretary may recommend to the Insurance Commissioner that the license of the company to transact such business be revoked, or suspended setting forth in detail the reasons for his recommendation. The Insurance Commissioner shall thereupon furnish a copy of the secretary's report to the insurer and shall set a date for public hearing, at which both the insurer and the secretary shall be afforded an opportunity to present evidence. If, after the hearing, the commissioner is satisfied that the insurer has failed to live up to his obligations under this act, he shall promptly revoke or suspend its license.

- (b) If any employer who is subject to this act as an approved self-insurer repeatedly or unreasonably fails to pay promptly compensation for which it is liable or fails or refuses to submit any report or to pay any assessment made under this act, the secretary may revoke or suspend the privilege granted to the employer to carry its own risk and require it to insure its liability. The secretary shall not take such action against any employer until the employer has been notified in writing of the charges made against it and has been given an opportunity to be heard before the secretary in answer to the charges.

- (c) Any person, not an insurer or self-insurer, engaged in the business of adjusting or servicing injury cases for the payment of compensation under this act shall register with the Department of Labor and Industry as a condition of conducting such business and shall furnish such reports of its activities as may be required by rules and regulations of the department. If any person engaged in such business repeatedly or unreasonably fails to provide such services promptly with the result that compensation is not paid promptly, the secretary may revoke or suspend the privilege of conducting such business. The secretary shall not take such action against such person

until such person has been notified in writing of the charges made against it by the secretary and has been given an opportunity to be heard before the secretary in answer to the charges. Proceedings for revocation of the privilege of conducting such service or adjustment business shall not relieve any insurer or self-insurer who has engaged in the services of such person from its responsibility under this act or from its liability to revocation under this section.

Sec 442 All counsel fees, agreed upon by claimant and his attorneys, for services performed in matters before any workers' compensation judge or the board, whether or not allowed as part of a judgment, shall be approved by the workers' compensation judge or board as the case may be, providing the counsel fees do not exceed twenty per centum of the amount awarded. The official conducting any hearing, upon cause shown, may allow a reasonable attorney fee exceeding twenty per centum of the amount awarded at the discretion of the hearing official.

In cases where the efforts of claimant's counsel produce a result favorable to the claimant but where no immediate award of compensation is made such as in cases of termination or suspension the hearing official shall allow or award reasonable counsel fees, as agreed upon by claimant and his attorneys, without regard to any per centum.

Sec 443 (a) If, in any case in which a supersedeas has been requested and denied under the provisions of section 413 or section 430, payments of compensation are made as a result thereof and upon the final outcome of the proceedings, it is determined that such compensation was not, in fact, payable, the insurer who has made such payments shall be reimbursed therefor. Application for reimbursement shall be made to the department on forms prescribed by the department and furnished by the insurer. Applications may be assigned to a workmen's compensation referee for a hearing and determination of eligibility for reimbursement pursuant to this act. An appeal shall lie in the manner and on the grounds provided in section 423 of this act, from any allowance or disallowance of reimbursement under this section.

(b) There is hereby established a special fund in the State Treasury, separate and apart from all other public moneys or funds of this Commonwealth, to be known as the Workmen's Compensation Supersedeas Fund. The purpose of this fund shall be to provide moneys for payments pursuant to subsection (a), to include reimbursement to the Commonwealth for any such payments made from general revenues. The department shall be charged with the maintenance and conservation of this fund. The fund shall be maintained by annual assessments on insurers and self-insurers under this act, including the State Workmen's Insurance Fund. The department shall make assessments and collect moneys pursuant to this section of the act. Assessments shall be based on the ratio that such insurer's or self-insurer's payments of compensation bear to the total compensation paid in the year preceding the year of assessment. The total amount to be assessed shall be one hundred percent of the amount reimbursed to insurers and self-insurers in the preceding year pursuant to this section, except that the first annual assessment made under this act shall be in the amount of two hundred fifty thousand dollars (\$250,000). The department shall give notice to every insurer and self-insurer under this act, including the State Workmen's Insurance Fund, of the amount assessed against such insurer, self-insurer or the State Workmen's Insurance Fund on or before June 30 of the year following the year upon which the assessment is based: Provided, That notice of the first annual assessment under this act shall be given to every insurer and self-insurer under this act, including the State Workmen's Insurance Fund, within ninety days of the effective date of this amending act. Payment of assessments shall be made to the department within thirty days of receipt of notice of the amount assessed, unless the department specifies on the notices sent to all insurers and self-insurers an installment plan of payment, in which case each such insurer shall pay each installment on or before the date specified therefore by the department within fifteen days after the receipt of such notice, the insurer or self-insurer against which such assessment has been made may file with the department objections setting out in detail the grounds upon which the objector regards such assessment to be excessive, erroneous, unlawful, or invalid. The department, after notice to the objector, shall hold a hearing upon such objections. After such hearing, the department shall record its findings on the objections and shall transmit to the objector,

by registered or certified mail, notice of the amount, if any, charged against it in accordance with such findings, which amount or any installment thereof then due, shall be paid by the objector within ten days after receipt of notice of the findings.

No suit or proceeding shall be maintained in any court for the purpose of restraining or in anywise delaying the collection or payment of any assessment made under this subsection but every insurer or self-insurer against which an assessment is made shall pay the same as provided in subsection (b) of this section. Any insurer or self-insurer making any such payment may, at any time within two years from the date of payment, sue the Commonwealth in an action at law to recover the amount paid, or any part thereof, upon the ground that the assessment was excessive, erroneous, unlawful, invalid, in whole or in part, provided objections, as hereinbefore provided, were filed with the department, and payment of the assessment was made under protest either as to all or part thereof. In any action for recovery of any payments made under this section, the claimant shall be entitled to raise every relevant issue of law, but the findings of fact made by the department, pursuant to this section, shall be prima facie evidence of the facts therein stated. If it is finally determined in any such action that all or any part of the assessment for which payment was made under protest was excessive, erroneous, unlawful, or invalid, the department shall make a refund to the claimant out of the appropriation specified in subsection (c) as directed by the court.

- (c) The department shall keep a record of the manner in which it shall have computed the amount assessed against every insurer or self-insurer. Such records shall be open to inspection by all interested parties. The determination of such assessments and the records and data upon which the same are made, shall be considered prima facie correct; and in any proceeding instituted to challenge the reasonableness or correctness of any assessment under this section, the party challenging the same shall have the burden of proof. The fund shall be subject to audit by the Auditor General and a copy of the report of the audit furnished to assessed insurers and self-insurers upon request. The Secretary of Labor and Industry shall be the administrator of the fund and shall have the power to dispense and disburse moneys from the fund for the purpose of payments made pursuant to this section. All moneys in the fund as are required to carry out the purposes of this section are hereby specifically appropriated to the Department of Labor and Industry. The State Treasurer shall be custodian of the fund. Disbursements of moneys pursuant to this section shall be upon final adjudication of requests for payments pursuant thereto.

[Editor's Note: See "Additional Relevant Statutory Provisions," Appendix C, (8).]

Sec 444 No person who is qualified for or is receiving compensation under this act, shall, with respect to the same period, receive compensation under The Pennsylvania Occupational Disease Act: Provided, however, That any person may pursue, in the alternative, a claim for compensation under this act and a claim for compensation under The Pennsylvania Occupational Disease Act.

Sec 445 Annual reports of compensation paid by insurers, self-insurers and the State Workmen's Insurance Fund shall be made on a calendar year basis to the department not later than April 15 of the following year, except that for the year 1974 reports shall be filed within sixty days of the effective date of this amending act. Nothing in this act shall be construed to preclude insurers from filing its annual report required herein in substantially the same form as its annual report to the Insurance Department.

Sec 446 (a) There is hereby created a special fund in the State Treasury, separate and apart from all other public moneys or funds of this Commonwealth, to be known as the Workmen's Compensation Administration Fund. The purpose of this fund shall be to finance the operating and administrative expenses of the Department of Labor and Industry, including the Workmen's Compensation Appeal Board and staff, but not the State Workmen's Insurance Fund, in the direct administration of The Pennsylvania Workmen's Compensation Act and The Pennsylvania Occupational Disease Act including:

- (1) wages and salaries of employes for services performed in the administration of these acts;
 - (2) reasonable travel expenses for employes while engaged in official business; and
 - (3) moneys expended for office rental, equipment rental, supplies, equipment repairs, services, postage, books, and periodicals.
- (b) The fund shall be maintained by no more than one (1) annual assessment payable in any calendar year on insurers and self-insurers under this act, including the State Workmen's Insurance Fund. The initial assessment for the period commencing July 1, 1975 through December 31, 1976, shall be seven per centum of the total compensation paid by each insurer, self-insurer and the State Workmen's Insurance Fund in the calendar year 1974. After the initial term, budgeted expenses shall be approved by the General Assembly on a fiscal year basis. Thereafter, the department shall make assessments and collect moneys based on the ratio that such insurer's or self-insurer's payments of compensation bear to the total compensation paid in the preceding calendar year in which the assessment is made. The total amount assessed shall be the approved budget. If on January 31, there exists in the administration fund any money in excess of one hundred fifty per centum of the current budget the following fiscal year's assessment shall be reduced by an amount equal to that excess amount.
- (c) The department shall give notice to every insurer and self-insurer under this act, including the State Workmen's Insurance Fund, of the amount assessed against such insurer, self-insurer, or the State Workmen's Insurance Fund on or before November 30 of each year. Payment of assessments shall be made to the department on or before January 31 of the next year unless the department specifies on the notices sent to all insurers and self-insurers an installment plan of payment, in which case each such insurer shall pay each installment on or before the date specified therefore by the department: Provided, That notice of the initial assessment under this act shall be given to every insurer and self-insurer under this act, including the State Workmen's Insurance Fund, within ninety days of the effective date of this amendatory act. Payment of the initial assessments shall be made within thirty days of the mailing of said assessments.

If the General Assembly fails to approve the department's budget for the purposes of this act, by the last day of November, the department shall assess insurers, self-insurers and the State Workmen's Insurance Fund on the basis of that last approved operating budget. At such time as the General Assembly approves the proposed budget the department shall have the authority to make an adjustment in the assessments to reflect the approved budget. If the General Assembly fails to approve the department's budget prior to July 1 of any fiscal year, moneys in the fund are hereby appropriated to the department for the purposes of this act.

Within fifteen days after the receipt of such notice, the insurer or self-insurer against which such assessment has been made may file with the department objections setting out in detail the grounds upon which the objector regards such assessment to be excessive, erroneous, unlawful, or invalid. The department, after notice to the objector, shall hold a hearing upon such objections. After such hearing, the department shall record its findings on the objections and shall transmit to the objector, by registered or certified mail, notice of the amount, if any, charged against it in accordance with such findings, which amount or any installment thereof then due, shall be paid by the objector within ten days after receipt of notice of the findings. If any payment prescribed by this subsection is not made as aforesaid, the secretary of the department may recommend to the Insurance Commissioner that appropriate action be taken against the insurer or self-insurer, including revocation or suspension of the company's license to transact business in the Commonwealth.

No suit or proceeding shall be maintained in any court for the purpose of restraining or in anywise delaying the collection or payment of any assessment made under this subsection but every insurer or self-insurer against which an assessment is made shall pay the same as provided in subsection (c) of this section. Any insurer or self-insurer making any such payment may, at any

time within two years from the date of payment, sue the Commonwealth in an action at law to recover the amount paid, or any part thereof, upon the ground that the assessment was excessive, erroneous, unlawful, invalid, in whole or in part, provided objections, as hereinbefore provided, were filed with the department, and payment of the assessment was made under protest either as to all or part thereof. In any action for recovery of any payments made under this section, the claimant shall be entitled to raise every relevant issue of law, but the findings of fact made by the department, pursuant to this section, shall be prima facie evidence of the facts therein stated. If it is finally determined in any such action that all or any part of the assessment for which payment was made under protest was excessive, erroneous, unlawful, or invalid, the department shall make a refund to the claimant out of the fund, as directed by the court.

The department shall keep a record of the manner in which it shall have computed the amount assessed against every insurer or self-insurer. Such records shall be open to inspection by all interested parties. The determination of such assessments and the records and data upon which the same are made, shall be considered prima facie correct; and in any proceeding instituted to challenge the reasonableness or correctness of any assessment under this section, the party challenging the same shall have the burden of proof.

- (d) The Secretary of Labor and Industry shall be the administrator of the fund and shall have power to dispense and disburse moneys from the fund for the above purposes at his discretion. All moneys in the fund as are required to carry out the purposes of this act are hereby specifically appropriated to the Department of Labor and Industry for the use in the administration of this act from July 1, 1975 until June 30, 1976. Thereafter, annual appropriations shall be made. Estimates of the amounts to be expended from time to time shall however be submitted by the Secretary of Labor and Industry to the Governor for his approval or disapproval as in the case of other appropriations made to administrative departments, boards, and commissions. The State Treasurer shall be the custodian of the fund. It shall however be unlawful for the State Treasurer to honor any requisition for the expenditure of any moneys from the fund by the Secretary of Labor and Industry in excess of estimates approved by the Governor. The fund shall be audited by the Auditor General annually and a copy of the report of the audit furnished to assessed insurers and self-insurers upon request.
- (e) Annual reports of the total compensation paid by insurers, self-insurers, and the State Workmen's Insurance Fund shall be made on a calendar year basis to the department not later than April 15 of the following year: Provided, That reports for the calendar year 1974 shall be filed within sixty days of the effective date of this amending act. Nothing in this act shall be construed to preclude insurers from filing its annual report required therein in substantially the same form as its annual report to the Insurance Department.
- (f) Contributions to the fund created by this act, at the rates specified by this act, shall be allowed in full by the Insurance Commissioner and the insurers shall be permitted to fund on an immediate and prospective basis for these costs.
- (g) For the purposes of this section the terms "compensation" and "total compensation" shall include wage loss indemnity and payments for medical expenses under this act and under "The Pennsylvania Occupational Disease Act."
- (h) Until such time as a sufficient cash balance shall exist in the Workmen's Compensation Administration Fund to meet promptly the expenses of the Commonwealth payable from such fund, the State Treasurer is hereby authorized and directed, from time to time, to transfer to the Workmen's Compensation Administration Fund, if the same be deficient, from the General Fund, such sums as the Governor shall direct. Any sums so transferred shall be available for the purposes for which the fund to which they are transferred is appropriated by law. Such transfers shall be made hereunder upon warrant of the State Treasurer upon requisition of the Governor.

- (i) In order to reimburse the General Fund for such transfers, an amount equal to that transferred from the General Fund during any fiscal period shall be retransferred to the General Fund from the Workmen's Compensation Administration Fund in such amounts and at such times as the Governor shall direct, but in no event later than 30 days after the end of such fiscal period. Such transfers shall be made hereunder upon warrant of the State Treasurer upon requisition of the Governor.
- (j) The moneys in the General Fund and in the Workmen's Compensation Administration Fund are hereby specifically appropriated for transfer from time to time as provided for in this act.

[Editor's Note: See "Additional Relevant Statutory Provisions," Appendix C, (8).]

Sec 447

- (a) There is hereby created an advisory council, to be known as the Pennsylvania Workers' Compensation Advisory Council. The council shall be comprised of eight members, with four members being employe representatives and four members being employer representatives. The Secretary of the Department of Labor and Industry shall be an ex officio member. The members of such council shall be appointed as follows: one employe representative and one employer representative by the President pro tempore of the Senate, one employe representative and one employer representative by the Speaker of the House of Representatives, one employe representative and one employer representative by the Minority Leader of the Senate and one employe representative and one employer representative by the Minority Leader of the House of Representatives. The members of the council shall select one of their number to be chairman.
 - (b)
 - (1) The council may hold hearings, receive testimony, solicit and receive comments from interested parties and the general public and shall have full access to information relating to the administration of this act by the Department of Labor and Industry. The council shall not have access to confidential medical information pertaining to individual claimants, but may develop statistical studies and surveys concerning aspects of incidence of injuries, claims management, litigation and adherence to the provisions of this act and the Occupational Disease Act.
 - (2) The council shall review annually any requests for funding by the department and any assessments against employers or insurers related thereto and provide a report to the Governor, the secretary and the General Assembly regarding the appropriateness of such requests.
 - (3) The council shall review proposed legislation and regulations pertaining to this act and provide comment at least quarterly to the Governor, the secretary and the General Assembly on the effects of such proposals.
 - (4) The council shall provide to the Governor, the secretary and the General Assembly, on an annual basis, a report on the activities of the council, making recommendations concerning needed improvements in the workers' compensation system and the administration of the system. The report under this paragraph shall be made during the General Assembly's consideration of the General Appropriations Act for the succeeding fiscal year. The report shall be due no later than May 1.
 - (5) The council shall make recommendations to the secretary regarding quality and cost-effective health care.
 - (6) The council shall review the annual accessibility study required by section 306(f.1)(3)(iv) and shall make recommendations to the secretary regarding the need for new allowances for health care providers.
 - (7) The council shall make recommendations to the secretary regarding the certification of coordinated care organizations and the approval of utilization review organizations and persons qualified to perform peer review.

(8) The council shall consult with health care providers and professional associations representing health care providers with regard to its recommendations under paragraphs (5), (6) and (7).

(c) The members of the advisory council, once appointed, shall serve a term of two years and until their successors have been appointed. Members shall serve without compensation, but shall be entitled to be reimbursed for all necessary expenses incurred in the discharge of their duties. The secretary shall provide facilities and clerical and professional support as needed by the council in the performance of its duties. The compensation of such staff and the amounts allowed them and to members of the council for traveling and other council expenses shall be deemed part of the expenses incurred in connection with the administration of this act.

Sec 448

(a) An insurer issuing a workers' compensation and employers' liability insurance policy shall offer, upon request, as part of the policy or by endorsement, deductibles optional to the policyholder for benefits payable under the policy, subject to approval by the commissioner and subject to underwriting by the insurer consistent with the principles in clause (b). The commissioner shall promulgate at least three (3) plans with varying deductible options, the least amount of which shall be no less than one thousand dollars (\$1,000) nor more than two thousand five hundred dollars (\$2,500). The commissioner's authority to promulgate any such plans shall not preclude an insurer from negotiating a deductible in excess of the largest deductible plan herein authorized, subject to approval by the commissioner and subject to underwriting by the insurer consistent with the principles in clause (b).

(b) The following standards shall govern the commissioner's promulgation and an insurer's offer of deductible plans:

(1) Claimants' rights are properly protected and claimants' benefits are paid without regard to any such deductible.

(2) Appropriate premium reductions reflect the type and level of any deductible approved by the commissioner and selected by the policyholder.

(3) Premium reductions for deductibles are determined before application of any experience modification, premium surcharge or premium discount.

(4) Recognition is given to policyholder characteristics, including size, financial capabilities, nature of activities and number of employees.

(5) If the policyholder selects a deductible, the policyholder is liable to the insurer for the deductible amount in regard to benefits paid for compensable claims.

(6) The insurer pays all of the deductible amount applicable to a compensable claim to the person or provider entitled to benefits and then seeks reimbursement from the policyholder for the applicable deductible amount.

(7) Failure to reimburse deductible amounts by the policyholder to the insurer is treated under the policy in the same manner as nonpayment of premiums.

(c) An insurer issuing a workers' compensation and employers' liability insurance policy may offer an endorsement for deductible or retrospective rating plans for groups of five (5) or more employers, subject to approval by the commissioner and subject to underwriting by the insurer consistent with the principles in clause (b).

(d) The following standards shall govern the commissioner's authorization of an insurer's offer of a group deductible or retrospective plan endorsement:

- (1) Individual workers' compensation and employers' liability insurance policies will be issued for each member of the group.
 - (2) Each member will be held jointly and severally liable for the payment of premiums or deductible amounts with regard to benefits paid for compensable claims of the group as a whole.
- Sec 449
- (a) Nothing 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.
 - (b) Upon or after filing a petition, the employer or insurer may submit the proposed compromise and release by stipulation signed by both parties to the workers' compensation judge for approval. The workers' compensation judge shall consider the petition and the proposed agreement in open hearing and shall render a decision. The workers' compensation judge shall not approve any compromise and release agreement unless he first determines that the claimant understands the full legal significance of the agreement. The agreement must be explicit with regard to the payment, if any, of reasonable, necessary and related medical expenses. Hearings on the issue of a compromise and release shall be expedited by the department, and the decision shall be issued within thirty days.
 - (c) Every compromise and release by stipulation shall be in writing and duly executed, and the signature of the employe, widow or widower or dependent shall be attested by two witnesses or acknowledged before a notary public. The document shall specify:
 - (1) the date of the injury or occupational disease;
 - (2) the average weekly wage of the employe as calculated under section 309;
 - (3) the injury, the nature of the injury and the nature of disability, whether total or partial;
 - (4) the weekly compensation rate paid or payable;
 - (5) the amount paid or due and unpaid to the employe or dependent up to the date of the stipulation or agreement or death and the amount of the payment of disability benefits then or thereafter to be made;
 - (6) the length of time such payment of benefits is to continue;
 - (7) in the event of a lien for subrogation under section 319, the total amount of compensation paid or payable which should be allowed to the employer or insurer;
 - (8) in the case of death:
 - (i) the date of death;
 - (ii) the name of the widow or widower;
 - (iii) the names and ages of all children;
 - (iv) the names of all other dependents; and
 - (v) the amount paid or to be paid under section 307 and to whom payment is to be made;
 - (9) a listing of all benefits received or available to the claimant;

- (10) a disclosure of the issues of the case and the reasons why the parties are agreeing to the agreement; and
 - (11) the fact that the claimant is represented by an attorney of his or her own choosing or that the claimant has been specifically informed of the right to representation by an attorney of his or her own choosing and has declined such representation.
- (d) The department shall prepare a form to be utilized by the parties for a compromise and release of any and all liability under this act in accordance with the stipulation requirements of this section, and it shall issue such rules and regulations necessary for it and the board to enforce the procedure allowed by this section. No compromise and release shall be considered for approval unless a vocational evaluation of the claimant is completed and filed with the compromise and release and made a part of the record: Provided, however, That this requirement may be waived by mutual agreement of the parties or by a determination of a workers' compensation judge as inappropriate or unnecessary. The vocational evaluation shall be completed:
- (1) by a qualified vocational expert approved by the department; or
 - (2) by the department on a fee-for-service basis.

Nothing in this clause shall serve to impose an obligation of liability or responsibility regarding vocational rehabilitation on either party or to require the implementation of vocational rehabilitation.

- Sec 450
- (a) Any employer and the recognized or certified and exclusive representative of its employe may agree by collective bargaining to establish certain binding obligations and procedures relating to workers' compensation: Provided, however, That the scope of the agreement shall be limited to:
 - (1) benefits supplemental to those provided in sections 306 and 307;
 - (2) an alternative dispute resolution system which may include, but is not limited to, arbitration, mediation and conciliation;
 - (3) the use of a limited list of providers for medical treatment for any period of time agreed upon by the parties;
 - (4) the use of a limited list of impartial physicians;
 - (5) the creation of a light duty, modified job or return to work program;
 - (6) the adoption of twenty-four-hour medical coverage; and
 - (7) the establishment of safety committees; and
 - (8) a vocational rehabilitation or retraining program.
 - (b) Nothing contained in this section shall in any manner affect the rights of an employer or its employes in the event that the parties to a collective bargaining agreement refuse or fail to reach agreement concerning the matters referred to in clause (a). In the event a municipality and its police or fire employes fail to agree by collective bargaining concerning matters referred to in clause (a), nothing in this section shall be binding upon the municipality or its police or fire employes as a result of an arbitration ruling or award.
 - (c) Nothing in this section shall allow any agreement that diminishes an employe's entitlement to benefits as otherwise set forth in this section. Any agreement in violation of this provision shall be null and void.

- (d) (1) Determinations rendered as a result of an alternative dispute resolution procedure shall remain in force during a period in which the employer and a recognized or certified exclusive collective bargaining representative are renegotiating a collective bargaining agreement.
- (2) Upon the expiration of an agreement which contains a provision for an alternative dispute resolution procedure for workers' compensation claims, the resolution of claims relating to injuries sustained as a result of a work-related accident or occupational disease may, if the agreement so provides, be subject to the terms and conditions set forth in the expired agreement until the employer and a recognized or certified exclusive bargaining representative agree to a new agreement.
- (3) Upon the termination of an agreement which is not subject to renegotiation and upon severance of the employment relationship, the employer and employees shall become fully subject to the provisions of this act to the same extent that they were prior to the implementation of the agreement.

ARTICLE V
General Provisions

Sec 501 No claim or agreement for legal services or disbursements in support of any demand made or suit brought under the provisions of article two of this act shall be an enforceable lien against the amount to be paid as damages, or be valid or binding in any respect, unless the same be approved in writing by the judge presiding at the trial, or, in case of settlement without trial, by a judge of the common pleas court of the county in which the injury occurred.

No claim or agreement for legal services or disbursements in support of any claim for compensation, or in preparing any agreement for compensation, under article three of this act, shall be an enforceable lien against the amount to be paid as compensation, or be valid or binding in any other respect, unless the same be approved by the board. Any such claim or agreement shall be filed with the department, which shall, as soon as may be, notify the person by whom the same was filed of the board's approval or disapproval thereof, as the case may be.

After the approval as herein required, if the employer be notified in writing of such claim or agreement for legal services and disbursements, the same shall be a lien against any amount thereafter to be paid as damages or compensation: Provided, however, That where the employe's compensation is payable by the employer in periodical instalments, the board shall fix, at the time of approval the proportion of each instalment to be paid on account of legal services and disbursements, and the board may upon application made to it commute the sum awarded for legal services and disbursements.

Sec 502 If any provision of this act shall be held by any court to be unconstitutional, such judgment shall not affect any other section or provision of this act, except that articles two and three are hereby declared to be inseparable and as one legislative thought, and if either article be declared by such court void or inoperative in an essential part, so that the whole of such article must fall, the other article shall fall with it and not stand alone.

Sec 503 Nothing in this act shall affect or impair any right of action which shall have accrued before this act shall take effect, except that, because litigation is now pending as to the constitutionality of the compensation schedules contained in the amendment of this act, approved the fourth day of June, one thousand nine hundred and thirty-seven (Pamphlet Laws, one thousand five hundred fifty-two), the department is hereby authorized to approve agreements or supplemental agreements, and the board and referees are hereby authorized to make awards effectuating agreements, compromising disputes between employers and employes or their dependents, as to the amount of compensation payable in cases arising out of injuries occurring between January first, one thousand nine hundred and thirty-eight and the effective date of this reenactment of this act, if such agreements or supplemental agreements provide for, or the parties to cases pending before the board or referees have agreed to, the payment of compensation at the rates and for the periods specified in this reenactment of this act.

ARTICLE VI
Additional Coverages

- Sec 601 (a) In addition to those persons included within the definition of the word “employee” as defined in section 104, “employee” shall also include:
- (1) members of volunteer fire departments or volunteer fire companies, including any paid fireman who is a member of a volunteer fire company and performs the services of a volunteer fireman during off-duty hours, who shall be entitled to receive compensation in case of injuries received while actively engaged as firemen or while going to or returning from a fire which the fire company or fire department attended including travel from and the direct return to a fireman’s home, place of business or other place where he shall have been when he received the call or alarm or while participating in instruction fire drills in which the fire department or fire company shall have participated or while repairing or doing other work about or on the fire apparatus or buildings and grounds of the fire company or fire department upon the authorization of the chief of the fire company or fire department or other person in charge or while answering any emergency calls for any purpose or while riding upon the fire apparatus which is owned or used by the fire company or fire department or while performing any other duties of such fire company or fire department as authorized by the municipality or while performing duties imposed by section 15, act of April 27, 1927 (P.L. 465, No. 299), referred to as the Fire and Panic Act;
 - (2) all members of volunteer ambulance corps of the various municipalities who shall be and are hereby declared to be employes of such municipality for the purposes of this act who shall be entitled to receive compensation in the case of injuries received while actually engaged as ambulance corpsmen or while going to or returning from any fire, accident, or other emergency which such volunteer ambulance corps shall attend including travel from and the direct return to a corpsman’s home, place of business or other place where he shall have been when he received the call or alarm; or while participating in ambulance corps of which they are members; or while repairing or doing other work about or on the ambulance apparatus or buildings and grounds of such ambulance corps upon the authorization of the corps president or other person in charge; or while answering any emergency call for any purpose or while riding in or upon the ambulance apparatus owned by the ambulance corps of which they are members at any time or while performing any other duties of such ambulance corps as are authorized by the municipality;
 - (3) members of volunteer rescue and lifesaving squads of the various municipalities who shall be and are hereby declared to be employes of such municipalities for the purposes of this act and who shall be entitled to receive compensation in the case of injuries received while actually engaged as a rescue and lifesaving squad member attending to any emergency to which that squad has been called or responded including travel from and the direct return to a squad person’s home, place of business or other place where he shall have been when he received the call or alarm or while participating in rescue and lifesaving drills in which the squad is participating; while repairing or doing other work about or on the apparatus, buildings and grounds of such rescue and lifesaving squad upon the authorization of the chief or other person in charge; or while riding in or upon the apparatus of the rescue and lifesaving squad and at any time while performing any other duties authorized by the municipality;
 - (4) volunteer members of the State Parks and Forest Program, who shall be declared to be employes of the Commonwealth for the purposes of this act, shall be entitled to receive compensation in case of injuries received while actually engaged in performing any duties in connection with the volunteers in the State Parks and Forest Program;
 - (5) Pennsylvania Deputy Game Protectors are hereby defined to be employes of the Commonwealth for all the purposes of this act and shall be entitled to receive compensation in case

of injuries received while actually engaged in the performance of duties as a Pennsylvania Deputy Game Protector whether employed by the Game Commission or otherwise;

- (6) all special waterways patrolmen are hereby declared to be employes of the Commonwealth for all purposes of this act and shall be entitled to receive compensation in case of injuries received while actually engaged in the performance of their duties as special waterways patrolmen whether actually receiving compensation from the Pennsylvania Fish Commission or not;
 - (7) all forest firefighters are hereby declared to be employes of the Commonwealth for the purpose of this act and shall be entitled to receive compensation in case of injuries received while actually engaged in the performance of their duties as forest firefighters or forest fire protection employes which duties shall include participation in the extinguishing of forest fires or traveling to and from forest fires or while performing any other duties relating to forest fire protection as authorized by the Secretary of Environmental Resources or his designee.
 - (8) All volunteer members of hazardous materials response teams who shall be and are hereby declared to be employes of the Commonwealth agency, county, municipality, regional hazardous materials organizations, volunteer service organization, corporation, partnership or of any other entity which organized the hazardous materials response team for the primary purpose of responding to the release of a hazardous material. All such volunteer members of hazardous materials response teams shall be entitled, under this act, to receive compensation in the case of injuries received while actively engaged as hazardous materials response team members or while going to or returning from any emergency response incident or accident which the hazardous materials response team attended, including travel from and direct return to a team member's home, place of business or other place where the member shall have been when the member received the call or alarm to respond to the emergency incident or accident; or while participating in hazardous materials response drills or exercises in which the hazardous materials response team is participating; or while repairing or doing other work about or on the hazardous materials response team apparatus or buildings and grounds of the hazardous materials response team upon the authorization of the chief of the hazardous materials response team or other person in charge; or while answering any emergency calls for any purpose; or while riding upon the hazardous materials response team apparatus which is owned or used by the hazardous materials response team in responding to an emergency or drill or with the express permission of the chief of the team; or while performing any other duties of such hazardous materials response team as authorized by the Commonwealth agency, county, municipality, regional hazardous materials organization, volunteer service organization, corporation, partnership or any other entity which duly organized the hazardous materials response team.
- (b) In all cases where an injury which is compensable under the terms of this act is received by an employe as defined in this section, there is an irrebuttable presumption that his wages shall be at least equal to the Statewide average weekly wage for the purpose of computing his compensation under sections 306 and 307.
 - (c) Whenever any member of a volunteer fire company, volunteer fire department, volunteer ambulance corps, or rescue and lifesaving squad is injured in the performance of duties in State Parks and State Forest Land, they shall be deemed to be an employe of the Department of Environmental Resources.
 - (d) The term "municipality" when used in this article shall mean all cities, boroughs, incorporated towns, or townships.

ARTICLE VII
Insurance Rates

- Sec 701 It is the intent of the General Assembly:
- (1) To protect policyholders and the public against the adverse effect of excessive, inadequate or unfairly discriminatory rates.
 - (2) To encourage, as the most effective way to produce rates that conform to the standards of paragraph (1), independent action by and reasonable price competition among insurers.
 - (3) To provide formal regulatory controls for use if price competition fails.
 - (4) To authorize cooperative action among insurers in the ratemaking process and to regulate such cooperation in order to prevent practices that tend to bring about monopoly or to lessen or destroy competition.
 - (5) To provide rates that are responsive to competitive market conditions and to improve the availability of insurance in this Commonwealth.
- Sec 702 This article applies to the classification of risks, underwriting rules, expenses, losses and profits for insurance of employers and employees under this act, for insurance under the Occupational Disease Act and for insurance with respect to the Commonwealth as to liability under the Federal Coal Mine Health and Safety Act of 1969 (Public Law 91-173, 30 U.S.C. §§ 801 et seq.).
- Sec 703 As used in this article:
- “Classification system” or “classification” means the plan, system or arrangement for recognizing differences in exposure to hazards among industries, occupations or operations of insurance policyholders.
- “Department” means the Insurance Department of the Commonwealth.
- “Experience rating” means a rating procedure utilizing past insurance experience of the individual policyholder to forecast future losses by measuring the policyholder’s loss experience against the loss experience of policyholders in the same classification to produce a prospective premium credit, debit or unity modification.
- “Market” means the interaction in this State between buyers and sellers of workers’ compensation and employers’ liability insurance within this Commonwealth pursuant to the provisions of this article.
- “Provision for claim payment” means historical aggregate losses projected through development to their ultimate value and through trending to a future point in time, but excluding all loss adjustment or claim management expenses, other operating expenses, assessments, taxes, and profit or contingency allowances.
- “Rate” or “rates” means rate of premium, policy and membership fee or any other charge made by an insurer for or in connection with a contract or policy of insurance of the kind to which this article applies.
- “Rating organization” means one or more organizations situate within this Commonwealth, subject to supervision and to examination by the commissioner and approved by the commissioner as adequately equipped to perform the functions specified in this article on an equitable and impartial basis.
- “Statistical plan” means the plan, system or arrangement used in collecting data.
- “Supplementary rate information” means any manual or plan of rates, statistical plan, classification system,

rating schedule, minimum premium policy fee, rating rule, rate-related underwriting rule and any other information, not otherwise inconsistent with the purposes of this article, prescribed by rule of the commissioner.

“Supporting information” means the experience and judgment of the filer and the experience or data of other insurers or organizations relied on by the filer, the interpretation of any statistical data relied on by the filer, description or methods used in making the rates and any other similar information required to be filed by the commissioner.

- Sec 704 (a) The following standards shall apply to the making and use of rates under this article:
- (1) Rates may not be:
 - (i) excessive or inadequate as defined under this article; or
 - (ii) unfairly discriminatory.
 - (2) A rate may not be held to be excessive unless it is likely to produce a long-run profit that is unreasonably high in relation to the risk undertaken and the services to be rendered.
 - (3) A rate may not be held to be inadequate unless:
 - (i) it is unreasonably low for the insurance provided and continued use of it would endanger solvency of the insurer; or
 - (ii) the rate is unreasonably low for the insurance provided and the use of the rate by the insurer has had or, if continued, will have the effect of destroying competition or of creating monopoly.
- (b) In determining whether rates comply with standards under subsection (a), due consideration shall be given to:
- (1) Past and prospective loss experience within and outside this Commonwealth in accordance with sound actuarial principles.
 - (2) Catastrophe hazards.
 - (3) A reasonable margin for underwriting profit and contingencies.
 - (4) Dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders or members or subscribers.
 - (5) Past and prospective expenses, both countrywide and those specially applicable to this Commonwealth.
 - (6) Investment income earned or realized by insurers both from their unearned premium and from their loss reserve funds.
 - (7) All relevant factors within and outside this Commonwealth in accordance with sound actuarial principles.
- (c) As to the kinds of insurance to which this article applies, the systems of expense provisions included in the rates for use by an insurer or group of insurers may differ from those of any other insurers or groups of insurers to reflect the requirements of the operating methods of the insurer or group of insurers.

- Sec 705 (a) Each authorized insurer shall file with the commissioner all rates and supplementary rate information and all changes and amendments thereof made by it for use in this Commonwealth by the date they become effective. Each rating organization shall file with the commissioner a filing for the provision for claim payment and such other filings as are authorized pursuant to this article. The Secretary of Labor and Industry shall be a member of the board of directors or governing body of any rating organization.
- (b) An insurer may not make or issue a contract or policy of insurance of the kind to which this article applies, except in accordance with the filings which are in effect for the insurer as provided in this article.
- Sec 706 Each filing and any supporting information filed under this article shall, as soon as filed, be open to public inspection. Copies may be obtained by any person on request and upon payment of a reasonable charge.
- Sec 707 (a) Each workers' compensation insurer shall be a member of a rating organization. Each workers' compensation insurer shall adhere to the policy forms filed by the rating organization.
- (b) (1) Every workers' compensation insurer shall adhere to the uniform classification system and uniform experience rating plan filed with the commissioner by the rating organization to which it belongs: Provided, That the system and plan have been approved by the commissioner as part of the approval of the rating organization's most recent filing for the provision for claim payment.
- (2) (i) Subject to the conditions of this paragraph, an insurer may develop subclassifications of the uniform classification system upon which a rate may be made.
- (ii) Any subclassification developed under subparagraph (i) shall be filed with the rating organization and the commissioner thirty (30) days prior to its use.
- (iii) If the insurer fails to demonstrate that the data produced under a subclassification can be reported in a manner consistent with the rating organization's uniform statistical plan and classification system, the commissioner shall disapprove the subclassification.
- (c) Every workers' compensation insurer shall record and report its workers' compensation experience to a rating organization as set forth in the rating organization's uniform statistical plan approved by the commissioner.
- (d) (1) Subject to the approval of the commissioner, a rating organization shall develop and file rules reasonably related to the recording and reporting of data pursuant to the uniform statistical plan, the uniform experience rating plan and the uniform classification system.
- (2) Every workers' compensation insurer shall adhere to the approved rules and experience rating plan in writing and reporting its business.
- (3) An insurer shall not agree with any other insurer or with a rating organization to adhere to rules which are not reasonably related to the recording and reporting of data pursuant to the uniform classification system or the uniform statistical plan.
- (e) The experience rating plan shall have as a basis:
- (1) reasonable eligibility standards;
- (2) adequate incentives for loss prevention;

- (3) sufficient premium differential so as to encourage safety; and
 - (4) predictive accuracy.
- (f) (1) The uniform experience rating plan shall be the exclusive means of providing prospective premium adjustment based upon measurement of the loss producing characteristics of an individual insured.
- (2) An insurer may file a rating plan that provides for retrospective premium adjustments based upon an insured's past experience.
- (g) The commissioner shall promulgate a plan by which all insurers writing workers' compensation insurance in this Commonwealth shall grant premium discounts or assess premium surcharges to employers who do not qualify for the uniform experience rating plan in accordance with the following:
- (1) An employer who has not experienced a compensable employe lost-time injury during the most recent two-year period for which statistics are available shall receive a discount of five per centum on the amount of the workers' compensation insurance premium.
 - (2) An employer who has experienced two or more compensable employe lost-time injuries during the most recent two-year period for which statistics are available shall be assessed a surcharge of five per centum on the amount of the workers' compensation insurance premium.
 - (3) The premium discounts or premium surcharges established under this section shall be made on an annual basis but shall not be cumulative: Provided, however, That an employer is entitled to receive the premium discount provided by this section in addition to any other reductions or deviations in the insurance premiums available to all other nonexperienced-rated employers in the same classification. For any annual workers' compensation premium, an employer shall not receive a premium discount of more than five per centum and shall not be required to pay a surcharge of more than five per centum.
 - (4) Insurers writing workers' compensation insurance in this Commonwealth may file a schedule rating plan based upon defined risk characteristics. Prior approval of this plan by the commissioner is required. For purposes of this clause, "employer" shall include a municipality or a municipal pool.

- Sec 708 (a) The commissioner may investigate and determine whether or not rates in this Commonwealth under this article are excessive, inadequate or unfairly discriminatory.
- (b) In any such investigation and determination the commissioner shall follow the procedures specified in sections 709 and 710.

- Sec 709 (a) (1) Except as provided in subsection (d), the commissioner shall review each workers' compensation insurance filing made by a rating organization or an insurer as soon as reasonably possible after the filing has been made in order to determine whether it meets the requirements of this article. No filing for the provision for claim payment shall become effective prior to its approval by the commissioner unless the commissioner fails to approve or disapprove the filing within the time period described in subsection (b)(1) or any extension of that period under subsection (b)(2).
- (2) Notwithstanding the provisions of paragraph (1), any insurer filing for loss adjustment or claim management expenses, other operating expenses, assessments, taxes and profits or contingency allowances filed with the commissioner with respect to the period after

December 1, 1994, shall not be subject to the commissioner's approval unless such insurer's rates are found to be in violation of sections 704 and 711.

- (b)
 - (1) The effective date of each filing under this article shall be the date specified in the filing. The effective date of the filing may not be earlier than thirty (30) days after the date the filing is received by the commissioner or the date of receipt of the information furnished in support of the filing if such supporting information is required by the commissioner.
 - (2) The period during which the filing may not become effective may be extended by the commissioner for an additional period not to exceed one hundred fifty (150) days if the commissioner gives written notice within the period described in paragraph (1) to the insurer or rating organization which made the filing that the commissioner needs additional time for the consideration of the filing. No filing shall be made effective for any period prior to the later of the proposed effective date or the expiration of an extension by the commissioner pursuant to this paragraph.
 - (3) Upon written application by an insurer or rating organization, the commissioner may authorize a filing which the commissioner has reviewed to become effective before the expiration of the period described in paragraph (1).
 - (4) A filing shall be deemed to meet the requirements of this article unless disapproved by the commissioner within the period described in paragraph (1) or any extension thereof.
- (c)
 - (1) Subject to approval or disapproval under subsection (b), a rating organization shall file with the commissioner:
 - (i) On an annual basis, workers' compensation rates and rating plans that are limited to provision for claim payment.
 - (ii) Each workers' compensation policy form to be used by its members.
 - (iii) The uniform classification system.
 - (iv) The uniform experience rating plan and related rules.
 - (v) Any other information that the commissioner requests relevant to the foregoing and is otherwise entitled to receive under this article.
 - (2) Notwithstanding any other provisions of this article, the commissioner may approve or disapprove any filing by a rating organization without determining whether a reasonable degree of competition exists within the market.
- (d) If the loss cost provision in a schedule of workers' compensation rates for specific classifications of risks filed by an insurer does not differ from the provision for claim payment contained in the schedule of workers' compensation rates for those classifications filed by a rating organization under subsection (c) and approved pursuant to the provisions of this article, then the schedule of rates filed by the insurer shall not be subject to subsection (b) but shall become effective for the purposes of section 705.
- (e) Notwithstanding subsection (d), the commissioner may investigate and evaluate all workers' compensation filings to determine whether the filings meet the requirements of this article.
- (f) Notwithstanding the provisions of section 705, the commissioner may require any insurer or rating organization to comply with the requirements of subsection (b) if the commissioner has found pursuant to section 710 that a reasonable degree of competition does not exist within the workers' compensation insurance market.

- Sec 710
- (a) If the commissioner finds after a hearing that a rate is not in compliance with section 704 or that a rate had been set in violation of section 713, the commissioner shall order that its use be discontinued for any policy issued or renewed after a date specified in the order, and the order may prospectively provide for premium adjustment of any policy then in force. Except as provided in subsection (b), the order shall be issued within thirty (30) days after the close of the hearing or within a reasonable time extension as fixed by the commissioner. The order shall expire one (1) year after its effective date unless rescinded earlier by the commissioner.
 - (b)
 - (1) Pending a hearing, the commissioner may order the suspension prospectively of a rate filed by an insurer and reimpose the last previous rate in effect if the commissioner has reasonable cause to believe that:
 - (i) an insurer is in violation of section 704;
 - (ii) unless the order of suspension is issued, certain insureds will suffer irreparable harm;
 - (iii) the hardship insureds will suffer absent the order of suspension outweighs any hardship the insurer would suffer if the order of suspension were to issue; and
 - (iv) the order of suspension will cause no substantial harm to the public.
 - (2) In the event the commissioner suspends a rate under this subsection, the commissioner must, unless waived by the insurer, hold a hearing within fifteen (15) working days after issuing the order suspending the rate. In addition, the commissioner must make a determination and issue the order as to whether or not the rate should be disapproved within fifteen (15) working days after the close of the hearing.
 - (c)
 - (1) At any hearing to determine compliance with section 704, pursuant to subsection (a), the commissioner may first determine whether a reasonable degree of competition exists within the market and shall give a ruling to that effect. All insurers operating within such market shall have the burden of establishing that a reasonable degree of competition exists within that market. The commissioner shall consider all relevant factors in determining the competitiveness of the market, including:
 - (i) the number of insurers actively engaged in providing coverage;
 - (ii) market shares;
 - (iii) changes in market shares; and
 - (iv) ease of entry.
 - (2) If the commissioner determines that a reasonable degree of competition does not exist in the market, any insurer designated by the commissioner shall have the burden of justifying its rate in such market.
 - (3) All determinations made by the commissioner shall be on the basis of findings of fact and conclusions of law.
 - (4) If the commissioner disapproves a rate, the disapproval shall take effect not less than fifteen (15) days after his order and the last previous rate in effect for the insurer shall be reimposed for a period of one (1) year unless the commissioner approves a rate under subsection (d) or (e).
 - (d) Within one (1) year after the effective date of a disapproval order, no rate adopted to replace one

disapproved under such order may be used until it has been filed with the commissioner and not disapproved within thirty (30) days thereafter.

- (e) Whenever an insurer has no legally effective rates as result of the commissioner's disapproval of rates, the commissioner shall, on the insurer's request, specify interim rates for the insurer that are high enough to protect the interests of all parties and may order that a specified portion of the premiums be placed in a special reserve established by the insurer. When new rates become legally effective, the commissioner shall order the specially reserved funds or any overcharge in the interim rates to be distributed appropriately to the insureds or insurer, as the case may be, except that refunds to policyholders that are minimal may not be required.

- Sec 711
- (a)
 - (1) If the commissioner finds after hearing that competition is not an effective regulator of the rates charged or that a substantial number of companies are competing irresponsibly through the rates charged or that there are widespread violations of this article, the commissioner may adopt a rule requiring that any subsequent changes in the rates or supplementary rate information be filed with the commissioner at least thirty (30) working days before they become effective.
 - (2) In the event that the waiting period is imposed pursuant to paragraph (1), the commissioner may extend the waiting period for a period not to exceed thirty (30) additional working days by written notice to the filer before the first thirty-day period expires.
 - (b) In the event that the commissioner has entered an order pursuant to paragraph (1) of subsection (a), the commissioner may require the filing of supporting data as the commissioner deems necessary for the proper functioning of the rate monitoring and regulating process. The supporting data shall include:
 - (1) the experience and judgment of the filer and, to the extent the filer wishes or the commissioner requires, the experience and judgment of other insurers or rate service organizations;
 - (2) the filer's interpretation of any statistical data relied upon;
 - (3) a description of the actuarial and statistical methods employed in setting the rate; and
 - (4) any other relevant matters required by the commissioner.
 - (c) A rule adopted under this section shall expire not more than one year after issue. The commissioner may renew it for an additional one-year period after a hearing and appropriate findings under this section.
 - (d) Whenever a filing is not accompanied by the information as the commissioner has required under subsection (a), the commissioner may so inform the insurer and the filing shall be deemed to be made when the information is furnished.

- Sec 712
- (a) No rating organization shall provide any service relating to the rates of any insurance subject to this article, and no insurer shall utilize the service of such organization for those purposes unless the organization has obtained a license pursuant to this article.
 - (b) No rating organization shall refuse to supply services for which it is licensed in this Commonwealth to any insurer authorized to do business in this Commonwealth and offering to pay the fair and usual compensation for the services.

- Sec 713
- (a) As used in this section, the word "insurer" includes two or more affiliated insurers:
 - (1) under common management; or

- (2) under common controlling ownership or under other common effective legal control and in fact engaged in joint or cooperative underwriting, investment management, marketing, servicing or administration of their business and affairs as insurers.
- (b) An insurer or rating organization may not:
- (1) monopolize or attempt to monopolize or combine or conspire with any other person or persons or monopolize the business of insurance of any kind, subdivision, or class thereof;
 - (2) agree with any other insurer or rating organization to charge or adhere to any rate, although insurers and rating organizations may continue to exchange statistical information;
 - (3) make any agreement with any other insurer, rating organization or other person to unreasonably restrain trade;
 - (4) make any agreement with any other insurer, rating organization or other person where the effect of the agreement may be substantially to lessen competition in the business of insurance of any kind, subdivision, or class; or
 - (5) make any agreement with any other insurer or rating organization to refuse to deal with any person in connection with the sale of insurance.
- (c) An insurer may not acquire or retain any capital stock or assets of or have any common management with any other insurer if such acquisition, retention or common management substantially lessens competition in the business of insurance of any kind, subdivision or class.
- (d) A rating organization or member or subscriber thereof may not interfere with the right of any insurer to make its rates independently of that rating organization or to charge rates different from the rates made by that rating organization.
- (e) Except as required under section 707, a rating organization may not have or adopt any rule or exact any agreement, formulate or engage in any program which would require any member, subscriber or other insurer to:
- (1) utilize some or all of its services;
 - (2) adhere to its rates, rating plan, rating systems or underwriting rules; or
 - (3) prevent any insurer from acting independently.

Sec 714 Any rate in violation of section 713 shall be disapproved by the commissioner in accordance with the procedures prescribed in section 710, and each violator shall be subject to the penalties provided in section 720.

Sec 715 The commissioner may maintain an action to enjoin any violation of section 713.

Sec 716 Notwithstanding any other provision of this article, upon written application of an insurer stating its reasons therefor, accompanied by the written consent of the insured or prospective insured, filed with and approved by the commissioner, a rate in excess of that provided by a filing otherwise applicable may be used as to any specific risk.

Sec 717 (a) Each rating organization and every insurer to which this article applies which makes its own rates shall provide within this Commonwealth reasonable means whereby any person aggrieved by the application of its rating system may be heard in person or by the person's authorized representa-

tive on the person's written request to review the manner in which such rating system has been applied in connection with the insurance afforded the aggrieved person. For the purposes of this section, "reasonable means" shall include at least the following:

- (1) A committee to hear the appeals of aggrieved persons which is comprised of an equal number of representatives of employers and insurers.
 - (2) If travel is required for the aggrieved person to be heard in person, reimbursement to the aggrieved person for reasonable travel expenses.
- (b) If the rating organization or insurer fails to grant or reject the aggrieved person's request within thirty (30) days after it is made, the applicant may proceed in the same manner as if the application had been rejected.
- (c) Any party affected by the action of that rating organization or insurer on the request may, within thirty (30) days after written notice of that action, make application in writing for an appeal to the commissioner, setting forth the basis for the appeal and the grounds to be relied upon by the applicant.
- (d) The commissioner shall review the application and, if the commissioner finds that the application is made in good faith and that it sets forth on its face grounds which reasonably justify holding a hearing, the commissioner shall conduct a hearing held on not less than ten (10) days' written notice to the applicant and to the rating organization or insurer. The commissioner, after hearing, shall affirm or reverse the action.
- Sec 718 (a) Cooperation among rating organizations or among rating organizations and insurers in ratemaking or in other matters within the scope of this article is authorized if the filings resulting from that cooperation are subject to all the provisions of this article which are applicable to filings generally.
- (b) The commissioner may review these cooperative activities and practices, and, if after hearing the commissioner finds that any activity or practice is unfair, unreasonable or otherwise inconsistent with this article, the commissioner may issue a written order specifying in what respects that activity or practice is unfair, unreasonable or otherwise inconsistent with this article and requiring the discontinuance of that activity or practice.
- Sec 719 (a) A person or organization may not wilfully withhold information from or knowingly give false or misleading information which will affect the rates or premiums chargeable under this article to:
- (1) the commissioner; or
 - (2) any rating organization or any insurer.
- (b) A violation of this section shall subject the one who commits that violation to the penalties provided in section 720, and anyone who violates this section with intent to deceive commits perjury, and is subject to prosecution therefor in a court of competent jurisdiction.
- Sec 720 (a) Any person, organization or insurer found by the commissioner after notice and hearing to be guilty of a violation of any provision of this article, including a regulation of the commissioner adopted under this article, may be ordered to pay a penalty of five hundred dollars (\$500) for each violation. Upon finding such violation to be wilful, the commissioner may impose a penalty of not more than one thousand dollars (\$1,000) for each such violation in addition to any other penalty provided by law. The commissioner has the right to suspend or revoke or refuse to renew the license of any person, organization or insurer for violation of any of the provisions of this article.
- (b) The commissioner may determine when a suspension or revocation of license will become effec-

tive, and the suspension or revocation shall remain in effect for the period fixed by the commissioner unless the commissioner modifies or rescinds the suspension or revocation or until the order upon which the suspension or revocation is based is modified or reversed as the result of an appeal therefrom.

- (c) A fine may not be imposed nor a license suspended or revoked by the commissioner except upon written order stating the commissioner's findings made after a hearing held on not less than ten (10) days' written notice to the person, organization or insurer specifying the alleged violation.

Sec 721 All decisions and findings of the commissioner under this article shall be subject to judicial review in accordance with 2 Pa.C.S. (relating to administrative law and procedure).

Sec 722 The commissioner shall report to the General Assembly annually, beginning on December 31, 1993, on the status, operation and procedures for the determination of classification systems as they apply to this article.

ARTICLE VIII
Self-Insurance Pooling

Sec 801 The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

“Actuarially appropriate loss reserves” shall mean those reserves needed to pay known claims for compensation and expenses associated therewith and claims for compensation incurred but not reported and expenses associated therewith.

“Administrator” means an individual, partnership or corporation engaged by a fund’s plan committee to carry out the policies established by the plan committee and to provide day-to-day management of the fund.

“Compensation” includes compensation paid under this act or the Occupational Disease Act.

“Department” means the Department of Labor and Industry of the Commonwealth.

“Employer” means an employer as defined in section 103 of this act or as defined in section 103 of the Occupational Disease Act, where applicable.

“Excess insurance” means insurance purchased from an insurance company appropriately approved or authorized or licensed in this Commonwealth covering losses in excess of an amount established between the group and the insurer up to the limits of coverage set forth in the insurance contract on a specific per occurrence or per accident or annual aggregate basis.

“Fund” means a group self-insurance fund organized by employers to pool workers’ compensation liabilities and approved by the department under the authority of this act. A fund shall not be deemed to be an insurer or insurance company and shall not be subject to the provisions of the insurance laws and regulations, except as specifically otherwise provided herein.

“Homogeneous employer” means employers who have been assigned to the same classification series for at least one year or are engaged in the same or similar types of business, including political subdivisions.

“Independent actuary” means a member in good standing of the Casualty Actuarial Society or a member in good standing of the American Academy of Actuaries who has been identified by the Academy as meeting its qualification standards for signing casualty loss reserve opinions. Said actuary must not be an officer, director or employe of the fund or a member of the fund for which he or she is providing reports, certifications or services.

“Insolvent fund” means the inability of a fund to pay its outstanding liabilities as they mature as may be shown either by an excess of its required reserves and other liabilities over its assets or by not having sufficient assets to reinsure all of its outstanding liabilities after paying all accrued claims owed by it.

“Permit” means the document issued by the department to a fund which authorizes the fund to operate as a fund under the provisions of this act.

“Plan committee” means a committee composed of representatives of each employer participating in a fund.

“Political subdivision” means any county, city, borough, incorporated town, township, school district, vocational school district and county institution district, municipal authority or other entity created by a political subdivision pursuant to law.

“Security” means surety bonds, cash, negotiable securities of the United States Government or the Commonwealth or other negotiable securities, such as letters of credit, acceptable to the department

which are posted by the fund to guaranty the payment of compensation.

“Surplus” means that amount of moneys found in the trust to be in excess of all fixed costs and incurred losses attributed to the pool net any occurrence or aggregate excess insurance.

“Trust” means a written contract signed by the members of the fund which separates the legal and equitable rights to the moneys held by an independent trustee as a fiduciary for the benefit of employes of employers participating in the fund.

- Sec 802
- (a) Employers shall be permitted to pool their liabilities under this act and the Occupational Disease Act and their employers' liability through participation in a fund approved by the department.
 - (b) A group of homogeneous employers may be approved by the department to act as a fund if the proposed group:
 - (1) Includes five or more homogeneous employers.
 - (2) Is comprised of at least five members of which each have been employers for at least three years prior to the filing of the group's application.
 - (3) Has been created in good faith for the purpose of becoming a fund.
 - (4) Has, except for political subdivisions, an aggregate net worth of the employers participating calculated according to generally accepted accounting principles which equals or exceeds one million dollars (\$1,000,000) or such amount as may be adjusted and promulgated annually by the department and published in the Pennsylvania Bulletin to take effect January 1 of each year.
 - (5) Has a combined annual payroll of fund members multiplied by the rate utilized by the State Workmen's Insurance Fund which is equal to or greater than five hundred thousand dollars (\$500,000) as adjusted annually by the percentage increase in the Statewide average weekly wage or such amount as may be adjusted and promulgated annually by the department and published in the Pennsylvania Bulletin to take effect January 1 of each year.
 - (6) Guarantees benefit levels equal to those required by this act and the Occupational Disease Act.
 - (7) Demonstrates sufficient aggregate financial strength and liquidity to assure that all obligations under this act and the Occupational Disease Act will be met as required by that act and proposes a plan for the prompt payment of such benefits. Information documenting an individual member's financial strength and liquidity shall be presented to the department upon the department's request or with the application as required by the department.
 - (8) Executes a trust agreement under which each member agrees to jointly and severally assume and discharge the liabilities arising under this act and the Occupational Disease Act of each and every party to such agreement.
 - (9) Files with the department the proposed trust agreement.
 - (10) Provides for excess insurance with retention amounts in such amount as the department deems acceptable on a single accident (single occurrence) and aggregate excess basis. The department may waive the requirement for one or both types of excess insurance if convinced that the fund's financial strength is sufficient to assure payment of its obligations under this act and the Occupational Disease Act.
 - (11) Provides security in a form and amount prescribed by the department. This paragraph shall

not apply to pools created by and exclusively for political subdivisions or municipalities which self-insure.

- (12) Provides letters of intent from prospective fund members and evidence that each prospective member:
 - (i) Has never defaulted on compensation due under this act or the Occupational Disease Act as an individual self-insurer.
 - (ii) Has not been delinquent in payment of or canceled for nonpayment of workers' compensation premiums for a period of at least two (2) years prior to application.
 - (iii) Has not been found to have violated section 305 or 435 or the Occupational Disease Act as an individual self-insurer.
 - (iv) Has not been and is not in default on or owes money assessed under this act or the Occupational Disease Act.
 - (13) Provides that the fund will initiate and maintain a loss prevention and safety program of the nature and extent that would be required of members under the provisions of this act, the Occupational Disease Act or regulations promulgated hereunder.
 - (14) Provides for assessment upon employers participating in the fund to establish and maintain actuarially appropriate loss reserves and a plan for payment of such assessments.
 - (15) Provides proof of competent personnel and ample facilities within its own organization with respect to claims administration, underwriting matters, loss prevention and safety engineering or presents a contract with a reputable service company to provide such assistance.
 - (16) Meets the other criteria established by this act or by the department pursuant to regulations promulgated under this act or the Occupational Disease Act.
- (c) Each application for approval of a fund shall be accompanied by a nonrefundable fee of one thousand dollars (\$1,000), payable to the department, which shall be deposited in the Workmen's Compensation Administration Fund.

- Sec 803
- (a)
 - (1) The department shall, in accordance with section 802, review, approve or disapprove fund applications under such rules and requirements relating to applications under section 305 and the Occupational Disease Act as may be applicable and such rules and regulations as are specifically adopted with regard to fund applications.
 - (2) During the pendency of the processing of any fund application, the group of employers shall not operate as a fund.

(b) Permits shall identify an annual reporting period for the fund as established by the department.

Sec 804 All permits issued under this article shall remain in effect unless terminated at the request of the fund or revoked by the department.

Sec 805 (a) If at any time the fund is found to be insolvent, fails to pay any required assessments under this act or the Occupational Disease Act or fails to comply with any provision of this act or the Occupational Disease Act or with any rules promulgated thereunder, the department may revoke its permit after notice and opportunity for a hearing.

(b) In the case of revocation of a permit, the department may require the fund to insure or reinsure all

incurred liability with an authorized insurer. All fund members shall immediately obtain coverage required by this act.

- Sec 806
- (a) Members of said fund shall pay a minimum of twenty-five per centum of their annual assessment into the fund on or before the inception of the fund. The balance of the annual assessments shall be paid to the fund on a monthly, quarterly or semiannual basis as required by the fund's bylaws and approved by the department.
 - (b) Each member's annual assessment to the fund shall equal such member's annual payroll times the applicable rates utilized by the State Workmen's Insurance Fund minus the premium discount specified in Schedule Y as approved by the commissioner. Dividends may be returned to members in accordance with section 809.
 - (c) Nothing contained in this section shall preclude the assessment and payment of supplemental assessments as provided in section 810.

Sec 807

After the final permit approval date of the fund, prospective new members of the fund shall submit an application for membership to the fund's plan committee or administrator in a form approved by the department. This application shall include an agreement of joint and several liability as required in section 803. The administrator or plan committee may approve the application for membership pursuant to the bylaws of the fund. The application approved by the fund shall be filed with the department. The fund shall retain the authority to reject any applicant.

- Sec 808
- (a) Individual members may elect to terminate their participation in a fund or be subject to cancellation by the fund pursuant to the bylaws of the fund for nonpayment of premium or other violations. Any member withdrawing from a fund or member terminated by the fund for nonpayment of assessments shall remain fully obligated for claims incurred during the period of its membership in accord with fund bylaws, including, but not limited to, amounts owed as annual or supplemental assessments. Notice of termination of any participant shall be filed with the fund. The fund shall attach any such notices of termination to the renewal application filed with the department.
 - (b) The fund shall notify the department immediately if termination of a member causes the fund to fail to meet the requirements of section 802(b). Within fifteen (15) days of the notice of withdrawal or decision to expel, the fund shall advise the department of its plan to bring the fund into compliance with section 802(b). If the plan does not bring the fund into compliance with the requirements, the department shall immediately review and revoke its permit.
 - (c) The department shall not grant the request of any fund to terminate its permit unless the fund has insured or reinsured all incurred workers' compensation obligations with an authorized insurer under an agreement filed with and approved in writing by the department. These obligations shall include both known claims and expenses associated therewith and claims incurred but not reported and expenses associated therewith. These same requirements shall apply where the department revokes a permit.

Sec 809

Any fund may return to its members dividends based upon the recommendation of an independent actuary. Dividends shall not be returned if the payment of such dividends would impair the fund's ability to meet its obligations under this act or the Occupational Disease Act, nor shall dividends be returned prior to the beginning of the thirteenth month following the expiration of the preceding annual reporting period. The initial dividend payment for any annual reporting period shall not exceed thirty per centum of the surplus available for the applicable annual reporting period. The fund may, however, seek annual approval for payment of dividends from the surplus remaining from any annual reporting period which has been completed for at least twenty-five months or longer and may include such dividend payments with initial dividend payments from the subsequent annual reporting period.

- Sec 810 (a) If the assets of a fund are at any time insufficient to enable the fund to discharge its legal liabilities and other obligations and to maintain the actuarially appropriate loss reserves required of it under section 802(b)(14), the fund shall forthwith make up the deficiency or levy an assessment upon the fund members for the amount needed to make up the deficiency.
- (b) In the event of a deficiency in any annual reporting period, such deficiency shall be made up immediately either from surplus from a year other than the current year, assessment of the fund members if ordered by the fund or such alternate method as the department may approve or direct.
- (c) If the fund fails to assess its members or to otherwise make up such deficit within thirty (30) days, the department shall order it to do so.
- (d) If the fund fails to make the required assessment of its members within thirty (30) days after the department orders it to do so or if the deficiency is not fully made up within sixty (60) days after the date on which such assessment is made or within such longer period of time as may be specified by the department, the fund shall be deemed to be insolvent.
- (e) The department shall proceed against an insolvent fund in the same manner as the department would proceed against a self-insurer under Article IX.
- (f) In addition, in the event of the liquidation or default of a fund, the department may levy an assessment upon the fund members for such an amount as the department determines to be necessary to discharge all liabilities of the fund, including the reasonable cost of liquidation, and shall deposit such assessments into the Self-Insurance Guaranty Fund for distribution and payment by the Guaranty Fund as provided for in Article IX.
- Sec 811 The annual assessment of each fund member shall be based upon the annual payroll of fund members multiplied by the rates as utilized by the State Workmen's Insurance Fund for members minus any premium discounts. A fund may deviate from these rates and establish its own rates with the approval of an independent actuary and the department.
- Sec 812 Each fund shall request classifications for its participants from the bureau or bureaus approved by the commissioner and shall utilize those classifications making assessments based upon rates as utilized by the State Workmen's Insurance Fund for such classification except as provided in section 811. The fund shall pay the appropriate bureau a reasonable charge, approved by the commissioner, for this service. The fund may appeal classifications as provided in the applicable sections of the Insurance Company Law of 1921 for other employers.
- Sec 813 Each fund may invest any surplus moneys not needed for current obligations in United States Government obligations, United States Treasury notes, investment share accounts in any savings and loan association whose deposits are insured by a Federal agency and certificates of deposit issued by a duly chartered commercial bank. Deposits in savings and loan associations and commercial banks shall be limited to institutions in this Commonwealth and shall not exceed the federally insured amount in any one account. Investments may also be made in any permitted investments of capital or surplus of stock casualty insurance companies set forth in section 602 or 603 of the Insurance Company Law of 1921, as may be authorized by regulation approved by the commissioner.
- Sec 814 (a) Funds approved under this article shall purchase excess insurance by reason of any single accident or any single occurrence as provided in section 653 of the Insurance Company Law of 1921 and aggregate excess insurance. The department may waive the requirement for either single accident (single occurrence) or aggregate excess insurance or the requirement for both single accident (single occurrence) and aggregate excess insurance.
- (b) A policy of insurance by an insurance carrier may include provisions for aggregate excess insurance in addition to the single accident (single occurrence) excess insurance which is authorized

under section 653 of the Insurance Company Law of 1921.

- Sec 815
- (a) A report shall be prepared by each fund for each annual reporting period and shall be filed with the department and made available to each fund member.
 - (b) The information contained in the annual report shall include, for each member of the fund and the fund itself:
 - (1) Summary loss reports.
 - (2) An annual statement of the financial condition of the fund prepared by a certified public accountant and performed in accordance with generally accepted accounting principles.
 - (3) Reports of outstanding liabilities showing the number of claims, amounts paid to date and current reserves as certified by an independent actuary.
 - (4) Such other information as required by regulation of the department as may be applicable to applicants for self-insurance under section 305 and the Occupational Disease Act or regulations in regard to fund applications.
 - (c) The annual report shall be accompanied by a one thousand dollar evaluation fee.
 - (d) The department may, at any time, examine the affairs, transactions, accounts, records and assets of a fund, and the fund shall make all such items as are needed for such examination available to the department. The department shall bill the fund for the reasonable costs associated with such examinations.
 - (e) If at any time there is a change in the fund during an annual reporting period other than as set forth in section 808 that affects the ability of the fund to comply with the requirements of section 802(b), the fund shall notify the department of the change within thirty (30) days after such change.
- Sec 816 Each fund shall be assessed annually by the department in a like manner and amount as other insurers or self-insurers are now or hereafter assessed under this act and the Occupational Disease Act and shall pay such assessment in accordance with this act and the Occupational Disease Act. All contributions received in accordance with this section shall be deposited into the appropriate fund as required by the applicable provision of law.
- Sec 817 Any group of five (5) homogeneous employers who will provide to the fund an annual volume of premium of at least five hundred thousand dollars (\$500,000) may become subscribers as a group to the State Workmen's Insurance Fund for the purpose of insuring therein their liability to those of their employes. Such group shall become legally obligated to pay any employe compensation required by this act because of bodily injury by accident or disease, including death at any time resulting therefrom, sustained by such employe arising out of and in the course of his employment. Such group shall make a written application for subscription for group insurance to the board. Such application shall designate the name of the group subscriber and shall include such information as determined by the board as will allow the board to identify the employers and to adequately assess risks and premiums to be charged to employers to be insured by the fund under the group subscription.
- Sec 818 The department is authorized to promulgate rules and regulations for the administration and enforcement of this article.
- Sec 819 If an association of employers establishes more than one group under this article, the association may organize a single board of trustees to oversee the operations of the several groups: Provided, however, That each of the several groups shall be equally represented on the board.

ARTICLE IX
Self-Insurance Guaranty Fund

Sec 901 The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

“Compensation” means benefits paid pursuant to sections 306 and 307.

“Employer” means a self-insured employer or the employer as defined in this act.

“Guaranty Fund” or “fund” means the Self-Insurance Guaranty Fund established in section 902 for injuries and exposures occurring on or after the establishment of the Self-Insurance Guaranty Fund.

“Security” means surety bonds, cash, negotiable securities of the United States Government or the Commonwealth or other negotiable securities, such as letter of credit, acceptable to the department which are posted by the fund to guaranty the payment of workers’ compensation benefits.

“Self-insurer” means an employer exempted under section 305 or a group self-insurance fund permitted to operate under Article VIII.

Sec 902 (a) (1) There is hereby established a special fund to be known as the Self-Insurance Guaranty Fund.

(2) The fund shall be maintained as two distinct custodial accounts in the State Treasury as separate and distinct accounts subject to the procedures and provisions set forth in this article.

(b) The moneys in each custodial account shall consist of security and assessments, as defined in section 907 and interest accumulated thereon.

(c) The administrator shall establish and maintain the following two distinct and separate custodial accounts. The moneys and other assets in each account are not to be commingled or used to pay claims from the other account.

(1) Custodial account for self-insured employers for the exclusive benefit of claims arising from defaulting individual self-insured employers.

(2) Custodial account for self-insurance pooling as defined under section 801 for the exclusive benefit of claims arising from defaulting members of pooling arrangements.

(d) The secretary shall be the administrator of the fund and shall have the power to collect, dispense and disperse money from the fund.

Sec 903 The fund shall be maintained to make payments to any claimant or his dependents upon the default of the self-insurer liable to pay compensation due under this act and the Occupational Disease Act or costs associated therewith and shall be maintained in an amount sufficient to pay such compensation and costs or reasonably anticipated to be needed by virtue of default by self-insurers.

Sec 904 (a) When a self-insurer fails to pay compensation when due, the department shall determine the reasons for such failure.

(b) If the department determines that the failure to pay compensation is due to the self-insurer’s financial inability to pay compensation, the department shall notify the self-insurer of same and direct compensation to be paid within fifteen (15) days of such notice.

- (c) If the self-insurer fails to pay the compensation as directed and within the time set forth in this section, the department shall declare the self-insurer in default.
- (d) Whenever the department determines that a default has occurred, it shall:
 - (1) Investigate the circumstances surrounding the default, the amount of security available and the ability of the self-insured to cure the default.
 - (2) Determine whether the liabilities of the self-insurer for compensation exceed or are less than the security:
 - (i) If the liabilities are less than the security, the department shall demand the custodian of the security utilize the security to cure the default and the department shall monitor the situation to insure that compensation is paid as due under this act or the Occupational Disease Act.
 - (ii) If at any time the liabilities exceed or can reasonably be expected to exceed the security, in the opinion of the department, the department may order payment of the security into the fund's appropriate custodial account and shall order payment from the Guaranty Fund, as appropriate, to cure the default and insure that compensation is paid as due under this act or the Occupational Disease Act.

- Sec 905
- (a) When payments are ordered from the Guaranty Fund's appropriate custodial account, the fund assumes the rights and obligations of the self-insurer under this act or the Occupational Disease Act with regard to the payment of compensation and shall have and may exercise the rights set forth in this section.
 - (b) The Guaranty Fund shall have the right to:
 - (1) Institute and prosecute legal action against any self-insurer and each and every member of a fund, jointly and severally, on behalf of the employes of the self-insured employer or fund members' employes and their dependents to require the payment of compensation and the performance of any other obligations of the self-insurer under this act or the Occupational Disease Act.
 - (2) Appear and represent the Guaranty Fund in any proceedings in bankruptcy involving the self-insurer on whose behalf payments were made, including the ability to appear and move to lift any stay orders affecting payment of compensation.
 - (3) Obtain, in any manner or by the use of any process or procedure, including, but not limited to, the commencement and prosecution of legal action, reimbursement from a self-insurer and its successors, assigns and estate all moneys paid on account of the self-insurer's obligation assumed by the fund, including, but not limited to, reimbursement for all compensation paid as well as reasonable administrative and legal costs associated with such payment.
 - (4) Purchase reinsurance and take any and all other action which effects the purpose of the Guaranty Fund.

- Sec 906
- (a)
 - (1) Security or funds from security demanded and paid to the department under section 904 shall be deposited into the Guaranty Fund.
 - (2) These funds and interest thereon shall be segregated in individual custodial accounts within the Guaranty Fund by the custodian and maintained solely for the payment of compensation or costs associated therewith upon order of the department to the employes of the defaulting

self-insurer providing the security from the appropriate custodial account.

(3) If there are funds from security or interest thereon remaining in the individual account after all outstanding obligations of the insolvent self-insurer have been satisfied and the costs of administration and defense have been paid, such amount as remains shall be returned upon order of the department from the Guaranty Fund individual account to the self-insurer.

(b) Assessments made under section 907 and interest thereon shall be deposited into the Guaranty Fund's appropriate custodial account.

Sec 907

(a) On a date to be determined by the department following the effective date of this article, employers who are self-insurers as of that effective date shall pay an initial assessment of one-half per centum of the compensation paid by each self-insurer in the year preceding the assessment. Self-insurers who, prior to such effective date, were not self-insurers shall pay an assessment based on one-half per centum of their modified manual premium for the twelve (12) months immediately prior to becoming self-insurers.

(b) (1) The department may, in addition to the initial assessment, from time to time, assess each self-insurer a pro rata share of the amounts needed for the fund to carry out the requirements of this article.

(2) Such assessments shall be based on the ratio that each self-insurer's payments of compensation bears to the total compensation paid by all self-insurers in the year preceding the year of assessment.

(3) In no event shall a self-insurer be assessed in any one calendar year more than one per centum of the compensation paid by that self-insurer during the previous calendar year.

(c) A self-insurer which ceases to be a self-insurer shall be liable for any and all assessments made pursuant to this section during the period following the date its authority to self-insure is withdrawn, revoked or surrendered until such time as it has discharged all obligations to pay compensation which arose during the period of time said former self-insurer was self-insured. Assessments of such a former self-insurer shall be based on the compensation paid by the former self-insurer during the preceding calendar year on claims that arose during the period of time said former self-insurer was self-insured.

Sec 908

The department may promulgate rules and regulations for the administration and enforcement of this article.

ARTICLE X
Health and Safety

- Sec 1001 (a) Notwithstanding any other provision of law, an insurer desiring to write workers' compensation insurance in this Commonwealth shall maintain or provide accident and illness prevention services as a prerequisite for a license to write such insurance. Proof of compliance with this section shall be provided to the commissioner. Such services shall be adequate to furnish accident prevention required by the nature of its business or its policyholders' operations and shall include surveys, recommendations, training programs, consultations, analyses of accident causes, industrial hygiene and industrial health services to implement the program of accident prevention services. The insurer, pursuant to its responsibilities under this section shall employ or otherwise make available qualified accident and illness prevention personnel. Such personnel shall meet the qualifications set forth in regulations issued by the department.
- (b) A self-insured employer shall maintain an accident and illness prevention program as a prerequisite for retention of its self-insured status. Such program shall be adequate to furnish accident prevention required by the nature of its business and shall include surveys, recommendations, training programs, consultations, analyses of accident causes, industrial hygiene and industrial health services. The self-insured employer pursuant to its responsibilities under this section, shall employ or otherwise make available qualified accident and illness prevention personnel. Such personnel shall meet the qualifications set forth in regulations issued by the department.
- (c) The department may conduct inspections to determine the adequacy of the accident prevention services required by this section at least once every two (2) years for each insurer.
- (d) Notice that services required by this section are available to the employer from an insurer must appear in no less than ten-point bold type and must accompany each workers' compensation insurance policy delivered or issued for delivery in this Commonwealth.
- (e) At least once each year, each insurer must submit to the department detailed information on the type of accident prevention services offered or provided to the insurer's policyholders. The information must include:
- (1) The amount of money spent by the insurer on accident prevention services.
 - (2) The number and qualifications of field safety representatives employed by the insurer.
 - (3) The number of site inspections performed.
 - (4) Any accident prevention services for which the insurer contracts.
 - (5) A breakdown of the premium size of the risks to which the insurer provided services.
 - (6) Evidence of the effectiveness of and accomplishments in accident prevention.
- (f) Failure to maintain or provide the accident prevention services required by this section shall constitute a continuing civil violation subject to a maximum fine of two thousand dollars (\$2,000) per day for each day the accident prevention services are not maintained or provided. Each day of noncompliance with this section is a separate violation. All fines recovered under this section shall be paid to the department and deposited by the department into the Workmen's Compensation Administration Fund created by section 446 of this act.
- (g) The insurer, the agent, servant or employe of the insurer and the past and present employer and employe members of the safety committee established under section 1002 and any collective bargaining representative shall not be liable on any cause of action or in any proceeding, civil or

criminal, arising out of or based upon allegations and pleadings relating to the performance of services under or in compliance with this article. This immunity shall not, however, affect the liability of the employer or the insurer for compensation as otherwise provided in this act. The recommendations, findings and minutes of a safety committee shall not be admissible evidence in any civil action filed on behalf of an employee against a third party regarding any injury incurred in the course and scope of employment.

- Sec 1002
- (a) An insured employer may make application to the department for the certification of any established safety committee operative within its workplace, developed for the purpose of hazard detection and accident prevention. The department shall develop such certification criteria.
 - (b) Upon the renewal of the employer's workers' compensation policy next following receipt of department certification, the employer shall receive a five per centum discount in the rate or rates applicable to the policy for a period of one year. The five per centum discount shall continue for a total of five years if the employer, by affidavit, provides annual verification to the department and to the employer's insurer that the safety committee continues to be operative and continues to meet the certification requirements.

ARTICLE XI
Insurance Fraud

Sec 1101 The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

“Attorney” means an individual admitted by the Pennsylvania Supreme Court to practice law in this Commonwealth.

“Health care provider” means a person licensed or certified pursuant to law to perform health care activities.

“Insurance claim” means a claim for payment or other benefits pursuant to an insurance policy for workers’ compensation.

“Insurance policy” means a document setting forth the terms and conditions of a contract of insurance or agreement for workers’ compensation.

“Insurer” means a company, association or exchange defined by section 101 of the Insurance Company Law of 1921 and the State Workmen’s Insurance Fund, an unincorporated association of underwriting members, a hospital plan corporation, a professional health services plan corporation, a health maintenance organization, a fraternal benefit society, and a self-insured health care entity under the act of October 15, 1975 (P.L. 390, No. 111), known as the “Health Care Services Malpractice Act.”

“Person” means an individual, corporation, partnership, association, joint-stock company, trust or unincorporated organization. The term includes any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd’s insurer, fraternal benefit society, beneficial association and any other legal entity engaged or proposing to become engaged, either directly or indirectly, in the business of insurance, including agents, brokers, adjusters and health care plans as defined in 40 Pa.C.S. Chs. 61 (relating to hospital plan corporations), 63 (relating to professional health services plan corporations), 65 (relating to fraternal benefit societies) and 67 (relating to beneficial societies) and the act of December 29, 1972 (P.L. 1701, No. 364), known as the “Health Maintenance Organization Act.” For purposes of this article, health care plans, fraternal benefit societies and beneficial societies shall be deemed to be engaged in the business of insurance.

“Statement” means any oral or written presentation or other evidence of loss, injury or expense, including, but not limited to, any notice, statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or doctor records, X-ray, test result or computer-generated documents.

Sec 1102 A person, including, but not limited to, the employer, the employe, the health care provider, the attorney, the insurer, the State Workmen’s Insurance Fund and self-insureds, commits an offense if the person does any of the following:

- (1) Knowingly and with the intent to defraud a State or local government agency files, presents or causes to be filed with or presented to the government agency a document that contains false, incomplete or misleading information concerning any fact or thing material to the agency’s determination in approving or disapproving a workers’ compensation insurance rate filing, a workers’ compensation transaction or other workers’ compensation insurance action which is required or filed in response to an agency’s request.
- (2) Knowingly and with the intent to defraud any insurer presents or causes to be presented to any insurer any statement forming a part of or in support of a workers’ compensation insurance claim that contains any false, incomplete or misleading information concerning any fact or thing material to the workers’ compensation insurance claim.

- (3) Knowingly and with the intent to defraud any insurer assists, abets, solicits or conspires with another to prepare or make any statement that is intended to be presented to any insurer in connection with or in support of a workers' compensation insurance claim that contains any false, incomplete or misleading information concerning any fact or thing material to the workers' compensation insurance claim.
- (4) Engages in unlicensed agent or broker activity as defined by the act of May 17, 1921 (P.L. 789, No. 285), known as "The Insurance Department Act of 1921" knowingly and with the intent to defraud an insurer or the public.
- (5) Knowingly benefits, directly or indirectly, from the proceeds derived from a violation of this section due to the assistance, conspiracy or urging of any person.
- (6) Is the owner, administrator or employe of any health care facility and knowingly allows the use of such facility by any person in furtherance of a scheme or conspiracy to violate any of the provisions of this section.
- (7) Knowingly and with the intent to defraud assists, abets, solicits or conspires with any person who engages in an unlawful act under this section.
- (8) Makes or causes to be made any knowingly false or fraudulent statement with regard to entitlement to benefits with the intent to discourage an injured worker from claiming benefits or pursuing a claim.
- (9) Knowingly and with the intent to defraud makes any false statement for the purpose of avoiding or diminishing the amount of the payment in premiums to an insurer or self-insurance fund.
- (10) Knowingly and with intent to defraud, fails to make the report required under section 311.1.
- (11) Knowingly and with intent to defraud, receives total disability benefits under this act while employed or receiving wages.
- (12) Knowingly and with intent to defraud, receives partial disability benefits in excess of the amount permitted with respect to the wages received.

Sec 1103

- (a) A lawyer may not compensate or give anything of value to a nonlawyer to recommend or secure employment by a client or as a reward for having made a recommendation resulting in employment by a client; except that the lawyer may pay:
 - (1) the reasonable cost of advertising or written communication as permitted by the rules of professional conduct; or
 - (2) the usual charges of a not-for-profit lawyer referral service or other legal service organization.

Upon a conviction of an offense under this clause, the prosecutor shall certify the conviction to the disciplinary board of the Supreme Court for appropriate action, including suspension or disbarment.

- (b) With respect to a workers' compensation insurance benefit or claim, a health care provider may not compensate or give anything of value to a person to recommend or secure the provider's service to or employment by a patient or as a reward for having made a recommendation resulting in the provider's service to or employment by a patient, except that the provider may pay the reasonable cost of advertising or written communication as permitted by rules of professional conduct. Upon a conviction of an offense under this subsection, the prosecutor shall certify the conviction to the appropriate licensing board in the Department of State which shall suspend or revoke the health care provider's license.

- (c) A lawyer or health care provider may not compensate or give anything of value to a person for providing names, addresses, telephone numbers or other identifying information of individuals seeking or receiving medical or rehabilitative care for accident, sickness or disease, except to the extent a referral and receipt of compensation is permitted under applicable professional rules of conduct. A person may not knowingly transmit such referral information to a lawyer or health care professional for the purpose of receiving compensation or anything of value. Attempts to circumvent this subsection through use of any other person, including, but not limited to, employes, agents or servants, shall also be prohibited.

Sec 1104 If an insurance claim is made by means of computer billing tapes or other electronic means, it shall be a rebuttable presumption that the person knowingly made the claim if the person has advised the insurer in writing that claims will be submitted by use of computer billing tapes or other electronic means.

Sec 1105 (a) A person who violates section 1102 shall be guilty of a felony of the third degree, and, upon conviction thereof, shall be sentenced to pay a fine of not more than fifty thousand dollars (\$50,000) or double the value of the fraud or to undergo imprisonment for a period of not more than seven years, or both.

(b) A person who violates section 1103 shall be guilty of a misdemeanor of the first degree and, upon conviction thereof, shall be sentenced to pay a fine of not more than twenty thousand dollars (\$20,000) or double the amount of the fraud, or both.

(c) A health care provider or lawyer who is guilty of an offense under section 1102 while acting on behalf of others shall be subject to disciplinary action, including suspension or revocation of a license or certificate or recommendation for suspension or disbarment to the Supreme Court, on the same basis as a health care provider or lawyer who is guilty of an offense under section 1103.

Sec 1106 The court may, in addition to any other sentence authorized by law, sentence a person convicted of violating this section to make restitution under 18 Pa.C.S. §1106 (relating to restitution for injuries to person or property).

Sec 1107 An insurer and any agent, servant or employe thereof acting in the course and scope of his employment shall be immune from civil or criminal liability arising from the supply or release of written or oral information to any entity duly authorized to receive such information by Federal or State law or by Insurance Department regulations only if the information is supplied to the agency in connection with an allegation of fraudulent conduct on the part of any person relating to a violation of this article and the insurer, agent, servant or employe has reason to believe that the information supplied is related to the allegation of fraud.

Sec 1108 Nothing in this article shall be construed to prohibit any conduct by an attorney or law firm which is expressly permitted by the Rules of Professional Conduct of the Supreme Court, by statute or by regulation, or prohibit any conduct by a health care provider which is expressly permitted by law or regulation.

Sec 1109 (a) The district attorneys of the several counties shall have authority to investigate and to institute criminal proceedings for any violation of this article.

(b) In addition to the authority conferred upon the Attorney General by the act of October 15, 1980 (P.L. 950, No. 164), known as the "Commonwealth Attorneys Act," the Attorney General shall have the authority to investigate and to institute criminal proceedings for any violation of this section or any series of such violations involving more than one county of this Commonwealth or involving any county of this Commonwealth and another state. No person charged with a violation of this article by the Attorney General shall have standing to challenge the authority of the Attorney General to investigate or prosecute the case, and, if any such challenge is made, the challenge shall be dismissed and no relief shall be available in the courts of the Commonwealth to the person making the challenge.

- (c) Nothing in this act shall prevent prosecution under 18 Pa.C.S. § 4117 (relating to insurance fraud) or any other provision of law.

Sec 1110 Nothing contained in this article shall be construed to limit the regulatory or investigative authority of any department or agency of the Commonwealth whose functions might relate to persons, enterprises or matters falling within the scope of this article.

Sec 1111 (a) A person found by a court of competent jurisdiction, pursuant to a claim initiated by a prosecuting authority, to have violated any provision of section 1102 shall be subject to civil penalties of not more than five thousand dollars (\$5,000) for the first violation, ten thousand dollars (\$10,000) for the second violation and fifteen thousand dollars (\$15,000) for each subsequent violation. The penalty shall be paid to the prosecuting authority to be used to defray the operating expenses of investigating and prosecuting violations of this article. The court may also award court costs and reasonable attorney fees to the prosecuting authority.

(b) If a prosecuting authority has probable cause to believe that a person has violated this section, nothing in this clause shall be construed to prohibit the prosecuting authority and the person from entering into a written agreement in which that person does not admit or deny the charges but consents to payment of the civil penalty. A consent agreement may not be used in a subsequent civil or criminal proceeding, but notification thereof shall be made to the licensing authority if the person is licensed by a licensing authority of the Commonwealth so that the licensing authority may take appropriate administrative action.

(c) All fines and penalties imposed following a conviction for a violation of this article shall be collected in the manner provided by law and shall be paid in the following manner:

- (1) If the prosecutor is a district attorney, the fines and penalties shall be paid into the operating fund of the county in which the district attorney is elected.
- (2) If the prosecutor is the Attorney General, the fines and penalties shall be paid into the State Treasury and appropriated to the Office of Attorney General.

Sec 1112 A prosecution for an offense under this act must be commenced within five years after commission of the offense.

ARTICLE XII
Fraud Enforcement

Sec 1201 The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

“Antifraud plan” means the insurance antifraud plan required to be filed and maintained pursuant to this article.

“Commissioner” means the Insurance Commissioner of the Commonwealth.

“Department” means the Insurance Department of the Commonwealth.

Sec 1202 (a) The department is authorized to refer to the appropriate law enforcement official violations of Article XI if the department has reason to believe that a person has engaged in or is engaging in an act or practice that violates Article XI.

(b) The department shall furnish all papers, documents, reports, complaints or other facts or evidence to any police, sheriff or other law enforcement agency or governmental entity duly authorized to receive such information, when so requested, and shall assist and cooperate with those agencies.

Sec 1203 A workers’ compensation insurer shall institute and maintain an insurance antifraud plan.

Sec 1204 All workers’ compensation insurers shall annually provide to the department a summary report on actions taken under an antifraud plan to prevent and combat insurance fraud, including, but not limited to, measures taken to protect and ensure the integrity of electronic data processing-generated data and manually compiled data, statistical data on the amount of resources committed to combating fraud and the amount of fraud identified and recovered during the reporting period.

Sec 1205 (a) Every workers’ compensation insurer and its employes, agents and brokers are authorized to refer to the appropriate law enforcement official violations of Article XI if the insurer, employe, agent or broker has reason to believe that a person has engaged in or is engaging in an act or practice that violates Article XI.

(b) The insurer, its employes, agents and brokers, shall furnish all papers, documents, reports, complaints or other facts or evidence to any police, sheriff or other law enforcement agency or governmental entity duly authorized to receive such information, when so requested, and shall assist and cooperate with those agencies.

ARTICLE XIII
Small Business Advocate

Sec 1301 As used in this article:

“Department” means the Insurance Department of the Commonwealth.

Sec 1302 In addition to his powers and duties under the act of December 21, 1988 (P.L. 1871, No. 181), known as the “Small Business Advocate Act,” the small business advocate shall have standing to represent the interest of employers as a party in proceedings before the department or any court involving filings by rating organizations and insurers pursuant to Article VII.

Sec 1303 (a) In addition to any other assessment authorized by section 446, an additional annual assessment shall be made on insurers, including the State Workmen’s Insurance Fund but not including self-insureds, as a percentage of the total compensation paid, for the purpose of funding the operations of the Office of Small Business Advocate pursuant to this act. Assessments under this section shall be made by the department and deposited into the Workmen’s Compensation Administration Fund in a restricted account to be used by the Office of Small Business Advocate. The total amount assessed shall be the amount of the budget approved annually by the General Assembly for the operations of the Office of Small Business Advocate pursuant to this act.

(b) The total moneys assessed under the act of December 28, 1994 (P.L.1414, No.166), known as the Insurance Fraud Prevention Act, shall be permitted to be utilized by the Section of Insurance Fraud, within the Office of Attorney General, for prosecution and investigation of crimes arising under section 1102 and 18 Pa.C.S. § 4117 (relating to insurance fraud), as well as other grants by the Insurance Fraud Prevention Authority.

Sec 1304 Nothing contained in this article shall in any way limit the right of any person to bring a proceeding before either the department or a court.

ARTICLE XIV
Workers' Compensation Judges

- Sec 1401 (a) There is created within the department an office to be known as the Office of Adjudication.
- (b) The secretary shall appoint as many qualified and competent workers' compensation judges as necessary to conduct matters under this act.
- (c) The secretary shall set normal working hours for workers' compensation judges. During those hours, workers' compensation judges shall devote full time to their official duties and shall perform no work inconsistent with their duties as workers' compensation judges. Workers' compensation judges shall not engage in any unapproved activities during normal working hours.
- (d) Workers' compensation judges shall be afforded employment security as provided by the act of August 5, 1941 (P.L.752, No.286), known as the "Civil Service Act."
- (e) Compensation for workers' compensation judges shall be established by the Executive Board.
- (f) The secretary shall develop and require all workers' compensation judges to complete a course of training and instruction in the duties of their respective offices and pass an examination prior to assuming office. The course of training and instruction shall not exceed four weeks in duration and shall consist of a minimum of forty hours of class instruction in medicine and law.
- (g) The secretary shall develop a continuing professional development plan for workers' compensation judges which shall require the annual completion of twenty hours of approved continuing professional development courses.
- (h) The secretary may adopt additional rules to establish standards and procedures for the evaluation, training, promotion and discipline of workers' compensation judges.
- Sec 1402 (a) The secretary shall appoint a director of adjudication, who:
- (1) must meet the qualifications under section 1403;
- (2) shall serve at the pleasure of the secretary; and
- (3) shall report directly to the secretary or a designee.
- (b) The position of director of adjudication shall be part of the unclassified service, as provided for by the act of August 5, 1941 (P.L.752, No.286), known as the "Civil Service Act."
- (c) The director of adjudication shall be responsible for assigning a workers' compensation judge to every matter which may require the utilization of a workers' compensation judge. The director of adjudication shall also have other responsibilities as the secretary may prescribe.
- (d) The director of adjudication shall receive remuneration above that of any other workers' compensation judge.
- Sec 1403 Workers' compensation judges shall be management level employes and must meet the following minimum requirements:
- (1) Be an attorney in good standing before the Supreme Court.
- (2) Have five years of workers' compensation practice before administrative agencies or equivalent experience.

- (3) Complete the course of training and instruction and pass the examination under section 1401(f).
- (4) Meet the annual continuing professional development requirement established by the secretary under section 1401(g).
- (5) Conform to other requirements as established by the secretary.

Sec 1404 (a) A workers' compensation judge shall conform to the following code of ethics:

- (1) Avoid impropriety and the appearance of impropriety in all activities.
 - (2) Perform duties impartially and diligently.
 - (3) Avoid ex parte communications in any contested, on-the-record matter pending before the department.
 - (4) Abstain from expressing publicly, except in administrative disposition or adjudication, personal views on the merits of an adjudication pending before the department and require similar abstention on the part of department personnel subject to the workers' compensation judge's direction and control.
 - (5) Require staff and personnel subject to the workers' compensation judge's direction and control to observe the standards of fidelity and diligence that apply to a workers' compensation judge.
 - (6) Initiate appropriate disciplinary measures against department personnel subject to the workers' compensation judge's direction and control for unethical conduct.
 - (7) Disqualify himself from proceedings in which impartiality may be reasonably questioned.
 - (8) Keep informed about the personal and fiduciary interests of himself and his immediate family.
 - (9) Regulate outside activities to minimize the risk of conflict with official duties. A workers' compensation judge may speak, write or lecture, and reimbursed expenses, honorariums, royalties or other money received in connection therewith shall be disclosed annually. A disclosure statement shall be filed with the secretary and the State Ethics Commission and shall be open to inspection by the public during the normal business hours of the department and the commission during the tenure of the workers' compensation judge.
 - (10) Refrain from direct or indirect solicitation of funds for political, educational, religious, charitable, fraternal or civic purposes: Provided, however, That a workers' compensation judge may be an officer, a director or a trustee of such organizations.
 - (11) Refrain from financial or business dealings which would tend to reflect adversely on impartiality. A workers' compensation judge may hold and manage investments which are not incompatible with the duties of office.
 - (12) Conform to additional requirements as the secretary may prescribe.
 - (13) Uphold the integrity and independence of the workers' compensation system.
- (b) Any workers' compensation judge who violates the provisions of clause (a) shall be removed from office in accordance with the provisions of the act of August 5, 1941 (P.L.752, No.286), known as the "Civil Service Act."

Sec 1405 The secretary shall determine the appropriate staff, facilities and administrative support so that the duties of workers' compensation judges may be performed.

Sec 1406 Individuals who are currently serving as workers' compensation judges shall continue to serve as workers' compensation judges, subject to sections 1401(c) and 1404.

ARTICLE XV
State Workers' Insurance Fund

Sec 1501 As used in this article:

“Advisory council” means the Advisory Council to the State Workers’ Insurance Board.

“Board” means the State Workers’ Insurance Board.

“Bureau” means the Bureau of Workers’ Compensation of the Department of Labor and Industry.

“Downward deviation” means the extent to which the State Workers’ Insurance Board provides deviations under section 654 of the act of May 17, 1921 (P.L.682, No.284), known as “The Insurance Company Law of 1921,” in the premiums charged to State Workers’ Insurance Fund subscribers below the otherwise applicable premium rates approved by the Insurance Commissioner for use by the board.

“Fund” means the State Workers’ Insurance Fund.

“Reserve funds” means the Sunny Day Fund and the Tax Stabilization Reserve Fund, created by the act of July 1, 1985 (P.L.120, No.32), entitled “An act creating a special fund in the Treasury Department for use in attracting major industry into this Commonwealth; establishing a procedure for the appropriation and use of moneys in the fund; establishing the Tax Stabilization Reserve Fund; and providing for expenditures from such account.”

“Safely distributable” means amounts which are distributable without jeopardizing the ability of the State Workers’ Insurance Fund to satisfy its present and future legal obligations to subscribers.

“Surplus” means the amount in the State Workers’ Insurance Fund in excess of the fund’s liabilities under this act.

“Taxes” means the amount that would be payable as taxes upon receipt of premiums by a private insurance company under section 902 of the act of March 4, 1971 (P.L.6, No.2), known as the “Tax Reform Code of 1971,” and the amount that would be payable as Federal income tax by a private insurance company under section 831 of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 831), or any amendments to either statute subsequently enacted. For purposes of computing Federal capital gains or losses (for such hypothetical Federal income tax under section 831 of the Internal Revenue Code of 1986) for periods after June 30, 1990, the basis of State Worker’s Insurance Fund assets will be the fair market value on June 30, 1990.

Sec 1502 The State Workers’ Insurance Board is hereby continued, consisting of the Secretary of Labor and Industry, the Insurance Commissioner and the State Treasurer.

Sec 1503 (a) The Advisory Council to the State Workers’ Insurance Board is hereby continued.

(b) The advisory council shall be appointed by the board and shall be composed of five members, with one member representing each of the following:

- (1) The Pennsylvania Chamber of Business and Industry or its successor organization.
- (2) The American Federation of Labor-Congress of Industrial Organizations (AFL-CIO) or its successor organization.
- (3) Insureds of the fund with premiums of five thousand dollars (\$5,000) or less annually.
- (4) Insureds of the fund with premiums of more than five thousand dollars (\$5,000) annually.

(5) The board.

The member of the advisory council representing the board shall serve as chair of the advisory council. The member representing the Pennsylvania Chamber of Business and Industry shall be selected from a list of persons recommended by that organization or its successor. The member representing the AFL-CIO shall be selected from a list of persons recommended by that organization or its successor.

- (c) Each member shall serve a term of two (2) years, commencing on January 1 of each odd-numbered year, and shall serve until the board appoints a successor. The board shall make initial appointments within sixty (60) days of the effective date of this section.
- (d) Members of the advisory council shall receive no compensation; each member, however, shall be entitled to be reimbursed for reasonable and legitimate expenses incurred in the performance of his duties.
- (e) The advisory council shall have the following powers and duties:
 - (1) Commission, in its discretion, an actuarial study of the fund no more than once a year.
 - (2) Review any actuarial studies of the fund commissioned by the board under section 1511(b).
 - (3) Request and receive from the board copies of or access to audits of the fund.
 - (4) Recommend to the board annually the amount of surplus in the fund, if any, which is safely distributable.
 - (5) Recommend to the board annually the form in which any safely distributable surplus should be distributed if the board has determined that a safely distributable surplus exists.
 - (6) Request assistance from the board as may be necessary to fulfill the advisory council's statutory obligations under this section. The advisory council shall make no recommendation to the board unless that recommendation reflects the votes of a majority of advisory council members. Should a majority of the advisory council's members vote to commission an actuarial study of the fund independent of the board's actuarial study, the board shall pay for the reasonable and customary expense associated with the preparation of such a study.

Sec 1504 Certain sums to be paid by employers, as provided in this article, are hereby continued as a fund, hereafter to be known as the State Workers' Insurance Fund, for the purpose of insuring such employers against liability under Article III of this act and of assuring the payment of the compensation therein provided and for the purpose of insuring such employers against liability under the Federal Coal Mine Health and Safety Act of 1969 (Public Law 91-173, 30 U.S.C. § 801 et seq.) and the Longshore and Harbor Workers' Compensation Act (44 Stat. 1424, 33 U.S.C. § 901 et seq.) and of assuring the payment of benefits therein provided and further for the purpose of insuring such employers against liability for all sums such employer shall become legally obligated to pay any employe of his as damages because of bodily injury by accident or disease, including death at any time resulting therefrom, sustained by such employe arising out of and in the course of his employment. Such fund shall be administered by the board, without liability on the part of the Commonwealth, except as provided in this article, beyond the amount thereof, and shall be applied to the payment of such compensation.

Sec 1505 The State Treasurer shall be the custodian of the fund, and all disbursements therefrom shall be paid by him by check, upon requisition of the secretary. It shall not be necessary for the State Treasurer to audit the accounts which the requisition of the secretary calls upon him to pay and for making payments according to the requisition of the secretary without audit the State Treasurer shall not be under any liability whatsoever. The State Treasurer may deposit any portion of the fund not needed for immediate

use as other State funds are lawfully deposited, and the interest thereon shall be collected by him and placed to the credit of the fund.

- Sec 1506 On or before October 1 in each year, the board shall prepare and publish a schedule of premiums or rates of insurance for employers under Article III; employers who want insurance against liability under the Federal Coal Mine Health and Safety Act of 1969 (Public Law 91-173, 30 U.S.C. § 801 et seq.); employers who want insurance against liability under the Longshore and Harbor Workers' Compensation Act (44 Stat. 1424, 33 U.S.C. § 901 et seq.); and employers who want insurance against liability for all sums such employer shall become legally obligated to pay any employe of his as damages because of bodily injury by accident or disease, including death at any time resulting therefrom, sustained by such employe arising out of and in the course of his employment. This schedule shall be printed and distributed free of charge to employers. An employer may pay to the fund the amount of the premium appropriate to his business or domestic affairs and, upon payment thereof, shall thereafter be considered a subscriber to the fund and shall be insured as provided in this article for the year for which the premium is paid. This insurance shall cover all payments becoming due in any year because of accidents occurring during the year for which the premium is paid.
- Sec 1507 The board shall determine the amount of premiums which the subscribers to the fund shall pay and shall fix the premiums for insurance in accordance with the nature of their business and of the various employments of their employes, and the probable risk of injury to their employes. They shall fix the premiums at such an amount as shall be adequate to enable them to pay all sums which may become due and payable to the employes of such subscribers, under the provisions of Article III of this act, under the provisions of the Longshore and Harbor Workers' Compensation Act (44 Stat. 1424, 33 U.S.C. § 901 et seq.) and under the provisions of the Federal Coal Mine Health and Safety Act of 1969 (Public Law 91-173, 30 U.S.C. § 801 et seq.); and, by reason of a subscriber's liability for all sums, such subscriber shall become legally obligated to pay any employe of his as damages because of bodily injury by accident or disease, including death at any time resulting therefrom, sustained by such employe arising out of and in the course of his employment, and to create and maintain the surplus provided in section 1509 and to provide an adequate reserve sufficient to carry all policies and claims to maturity. In fixing the premiums payable by any subscriber, the board may take into account the condition of the plant, workroom, shop, farm, mine, quarry, operation and all other property or premises of such subscriber, in respect to the safety of those employed therein, as shown by the report of any inspector appointed by the board or by the department. The board may, from time to time, change the amount of premiums payable by any of the subscribers as circumstances may require and the condition of the plant, workroom, shop, farm, mine, quarry, operation or other property or premises of such subscribers, in respect to the safety of their employes, may justify. The board may increase the premiums of any subscriber neglecting to provide safety devices required by law or disobeying the rules or regulations made by the board under section 1515. The insurance of any subscriber shall not be effective until he shall have paid in full the premium so fixed and determined.
- Sec 1508 The board shall file with the bureau a notice setting forth the names and places of business of those employers who from time to time shall become subscribers to the fund.
- Sec 1509 The board shall set aside five per centum of all premiums collected for the creation of a surplus until this surplus shall amount to one hundred thousand dollars (\$100,000), and thereafter they may set apart such percentage, not exceeding five per centum, as in their discretion they may determine to be necessary to maintain such surplus sufficiently large to cover the catastrophe hazard of all the subscribers to the fund and to guarantee the solvency of the fund.
- Sec 1510 The board shall divide the subscribers into groups, in accordance with the nature of the business of such subscribers and the probable risk of injury therein, and they shall fix all premiums for each group in accordance with the experience thereof. Where the employes in any business are engaged in various employments in which the risk of injury is substantially different, the board may subdivide the employments into classes and shall fix the premium for each in accordance with the probable risk of injury therein.

Sec 1511 (a) The moneys in the fund are hereby made available and shall be paid:

- (1) For the expenses of administering the fund, including the purchase through the Department of General Services of surety bonds for such officers or employes of the board as may be required to furnish them, supplies, materials, motor vehicles, workers' compensation insurance covering the officers and employes of the board, and liability insurance covering vehicles purchased out of moneys of the fund and operated by the officers and employes of the board. In the event that the use of motor vehicles is required only temporarily, then such moneys in the fund are available for the payment to the Department of General Services for the use of such motor vehicles on a mileage basis, at such amount per mile as the Department of General Services, with the approval of the Governor, shall determine.
 - (2) For payment to the Treasury Department of the cost of making disbursements out of the fund, on behalf of the board, at such amounts as the Treasury Department, with the approval of the Executive Board, shall determine.
 - (3) For payment to the Department of General Services for space occupied in government buildings and for water, light, heat, power, telephone and other services utilized and consumed by the board, at such amounts as the Department of General Services, with the approval of the Executive Board, shall determine.
 - (4) For payment to the General Fund in amounts which would have been paid in taxes had the fund been subject to taxes for the period beginning on July 1, 1990, and thereafter. These payments shall be due annually, shall be calculated on a fiscal year basis and shall be paid in equal quarterly installments of the board's estimate of taxes for a fiscal year. Quarterly installments shall be paid after the end of each quarter, and the fourth quarterly installment for each fiscal year shall be adjusted upward or downward as necessary to pay in full the amount due.
- (b) The board shall retain the services of a certified actuary who shall be responsible for conducting an annual independent actuarial study of the fund. The purpose of the study shall be to assist the board in determining whether the moneys in the fund exceed the fund's liabilities and, if so, whether any portion of that surplus is safely distributable. Payment for the annual actuarial study shall be considered to be an expense of administering the fund. The precise nature and scope of the study shall be determined by the board. The study shall be made available to the advisory council under clause (e) of section 1503. All persons charged with the administration or management of the fund shall provide the actuary or his agents with the means, facilities and opportunity to examine all books, records and papers pertaining to the fund.
- (c) The board shall keep an accurate account of the money paid in premiums by the subscribers, the income derived from investment of premiums and the disbursement of amounts paid under clause (a). At the expiration of each calendar year after 1990 and upon review of the independent actuarial study conducted under clause (b) and advisory council recommendations, if any, the board shall determine if there is a surplus remaining in the fund after deductions are made for disbursements identified in clause (a), the unearned premiums on undetermined risks, the percentage of premiums paid or payable to create or maintain the surplus provided in section 1509 and the setting aside of an adequate reserve. If a surplus exists in the fund and, if, after reviewing the recommendations of the advisory council, if any, the board determines that a portion of the surplus is safely distributable, the board shall distribute the safely distributable surplus as follows:
- (1) An amount up to the amount of any downward deviation that had been granted to subscribers at the start of that calendar year may be transferred to the reserve funds, as appropriated by the General Assembly.
 - (2) At least one-half of any safely distributable surplus not transferred to the reserve funds

under paragraph (1) shall be available for appropriation by the General Assembly for distribution to subscribers or former subscribers who paid premiums in that calendar year in proportion to the premiums each such subscriber or former subscriber paid in that year.

- (3) Any portion of the remaining safely distributable surplus up to the amount distributed to subscribers or former subscribers pursuant to paragraph (2) may be transferred to the reserve funds, as appropriated by the General Assembly.

Any amount distributed to subscribers pursuant to paragraph (2) shall be distributed among the subscribers, in proportion to the premiums paid by them; and the proportionate share of such subscribers as shall remain subscribers to the fund shall be credited to the installment of premiums next due by them, and the proportionate share of such subscribers as shall have ceased to be subscribers in the fund shall be refunded to them, out of the fund.

- (d) No appropriation under clause (c) shall impair the actuarial soundness of the fund.

- Sec 1512 The board may invest any of the surplus or reserve belonging to the fund in such securities and investments as are authorized for investment by savings banks. All such securities or evidences of indebtedness shall be placed in the hands of the State Treasurer who shall be the custodian thereof. He shall collect the principal and interest thereof when due and pay the same into the fund. The State Treasurer shall pay for all such securities or evidences of indebtedness by check issued upon requisition of the secretary. All such payments shall be made only upon delivery of such securities or evidences of indebtedness to the State Treasurer. To all requisitions calling upon the State Treasurer to pay for any securities or evidences of indebtedness there shall be attached a certified copy of the resolution of the board authorizing the investment. The board may, upon like resolution, sell any of such securities.
- Sec 1513 The board shall have the power to make all contracts necessary for supplying medical, hospital, and surgical services, as provided in clause (e) of section 306.
- Sec 1514 The board shall have the power to reinsure any risk or join any insurance pool which it may deem necessary.
- Sec 1515 (a) The board shall be entitled to inspect the plant, workroom, shop, farm, mine, quarry, operation and all other property or premises of any subscriber and shall be entitled to examine from time to time the books, records and payrolls of any subscriber or intending subscriber for the purpose of determining the amount of the premium payable to such subscriber or intending subscriber. The board shall have the power to appoint those inspectors and auditors as may be necessary to carry out the powers given in this section. The board may, with the consent of the department and commissioner, cause this inspection and examination to be made by the inspectors of the department and the auditors of the Insurance Department. These inspectors and auditors shall have free access to all such premises, books, records and payrolls during the regular working and office hours.
- (b) The board shall make reasonable rules and regulations for the prevention of injuries upon the premises of the subscribers, and they may refuse to insure or may terminate the insurance of any subscriber who refuses to permit such examinations or disregards such rules or regulations and may forfeit one-half of the unearned premiums previously paid by him.
- Sec 1516 (a) Any employer subject to Article III and who shall desire to become a subscriber to the fund for the purpose of insuring his liability to his employes; and any employer who wants insurance under the Longshore and Harbor Workers' Compensation Act (44 Stat. 1424, 33 U.S.C. § 901 et seq.); and any employer who wants insurance under the Federal Coal Mine Health and Safety Act of 1969 (Public Law 91-173, 30 U.S.C. § 801 et seq.) and who shall desire to become a subscriber to the fund for the purpose of insuring his liability to his employes; and any employer who shall desire to become a subscriber to the fund for the purpose of insuring therein his liability for all sums the employer shall become legally obligated to pay any employe of his as damages because

of bodily injury by accident or disease, including death at any time resulting therefrom, sustained by such employe arising out of and in the course of his employment, shall make a written application for such insurance to the board. In the application, the applicant shall state:

- (1) The nature of the business or domestic affairs in which insurance is desired.
 - (2) The average number of employes expected to be employed in such business during the year for which insurance is sought and the average number of employes, if any, engaged in such business during the year previous to the application.
 - (3) The approximate money wages expected to be paid during the year for which insurance is sought and the money wages paid to such employes during the preceding year.
 - (4) The place where the business is to be transacted.
 - (5) The place where the employer's payroll and books of accounts are kept and where the employes are customarily paid.
 - (6) Such other facts and information as the board shall require.
- (b) When the employments are subdivided into classes, as provided in section 1510, the applicant shall state:
- (1) The number of employes of each class expected to be employed or previously employed.
 - (2) The approximate money wages expected to be paid or previously paid, as aforesaid, to employes of each class for which insurance is sought.
- (c) Upon submission of the application, the board shall make such investigations as it may deem necessary and, within thirty (30) days after the application, shall issue a certificate showing the classification or group in which such applicant is entitled to be placed and the amount of premium payable by such applicant for the year for which insurance is sought. No insurance shall be issued for a longer period than a single year.

Sec 1517 All premiums shall be payable to the State Treasurer who shall issue an appropriate receipt therefor, and such receipt, together with the certificate of the board specified in section 1516, shall be the evidence that the applicant has become a subscriber to the fund and is insured therein.

Sec 1518 Each subscriber to the fund shall, within one (1) month after his subscription has terminated, furnish a written statement to the board setting forth the maximum average and minimum number of employes insured in the fund that such subscriber had employed during the preceding year, and the actual amount of the money payroll of such employes for such year. When the board has subdivided the employments in any group into classes, as provided in section 1510, the subscriber shall state the number and actual amounts of the money payroll of such employes of each of such classes. Within thirty (30) days, the board shall state the account of each subscriber for that year, based on the facts thus proven, and shall render a copy of this statement to the subscriber. If the amount of the premium theretofore paid by a subscriber shall exceed the amount due according to such stated account, then the excess shall be forthwith refunded to the subscriber by payment out of the fund. If the amount shown by the statement exceeds the amount of the premium theretofore paid by the subscriber, the excess shall be forthwith due and payable by the subscriber into the fund, and until paid shall be a lien, as State taxes are a lien, upon the real and personal property of the subscriber and, if unpaid, shall be collectible as State taxes are now collectible, with interest at the rate of twelve per centum per annum commencing thirty (30) days after service of the copy of the account, which service shall be by registered mail.

Sec 1519 Any person who shall knowingly furnish or make any false certificate, application or statement required

in this article shall be guilty of a misdemeanor. Any subscriber who shall, after notice from the board, neglect or refuse to file the statement described in section 1518 within ten (10) days after such notice shall be liable to pay to the fund a penalty of ten dollars (\$10) for each day that such neglect or refusal shall continue, to be recovered at the suit of the fund.

- Sec 1520 (a) Any subscriber to the fund who shall, within seven (7) days after knowledge or notice of an accident to an employe in the course of his employment as required by section 311, have filed with the board a true statement of such knowledge or a true copy of the notice shall be discharged from all liability for the payment of compensation for the personal injury or death of such employe by such accident, and all such compensation due therefor under Article III shall be paid out of the fund. The report of the accident required by the act of July 19, 1913 (P.L.843, No.408), referred to as the Employee Injury Reporting Law, shall be sufficient compliance with this section if that report is made within seven (7) days of the injury and shall state that the employer making the report is a subscriber to the fund.
- (b) Nothing in this section shall discharge any employer from the duty of supplying the medical and surgical services, medicine, and supplies required by section 306. Any subscriber who has supplied such services, medicines and supplies shall be reimbursed therefor from the fund. Any subscriber to the fund who, within seven (7) days after knowledge of an accident to any employe arising out of and in the course of his employment and such accident comes within the purview of the Federal Coal Mine Health and Safety Act of 1969 (Public Law 91-173, 30 U.S.C. § 801 et seq.) or of the Longshore and Harbor Workers' Compensation Act (44 Stat. 1424, 33 U.S.C. § 901 et seq.), has filed with the board a true statement of such knowledge shall be discharged from all liability for the payment of benefits for the personal injury or death of such employe by such accident, and all such benefits due therefor under provisions of the Longshore and Harbor Workers' Compensation Act or the Federal Coal Mine Health and Safety Act of 1969 shall be paid out of the fund. Any subscriber to the fund who shall, within seven (7) days after knowledge of an accident to an employe arising out of and in the course of his employment, have filed with the board a true statement of such knowledge shall be discharged from all liability for all sums such subscriber shall become legally obligated to pay any employe of his as damages because of bodily injury by accident or disease, including death at any time resulting therefrom, sustained by such employe arising out of and in the course of his employment, and all such sums shall be paid out of the fund.
- Sec 1521 In every case where a claim is made against the fund, the fund shall be entitled to every defense against such claim that would have been open to the employer and shall be subrogated to every right of the employer arising out of such accident against the employe, the dependents and against third persons. The fund may, in the name of the State Workers' Insurance Fund, sue or be sued to enforce any right given against or to any subscriber or other person under this act or the Longshore and Harbor Workers' Compensation Act (44 Stat. 1424, 33 U.S.C. § 901 et seq.) or the Federal Coal Mine Health and Safety Act of 1969 (Public Law 91-173, 30 U.S.C. § 801 et seq.) and employers who want insurance against liability for all sums or under circumstances where an employer becomes legally obligated to pay any employe for damages because of bodily injury by accident or disease, including death at any time resulting therefrom, sustained by such employe arising out of and in the course of his employment; proceedings provided in Article IV may be instituted by or against the fund to enforce, before the Workers' Compensation Appeal Board or any workers' compensation judge thereof, the rights given to or against the fund by this act.
- Sec 1522 Upon receipt of a notice or statement of knowledge of an accident to an employe of a subscriber occurring in the course of his employment, the board shall, if it deems necessary, cause an investigation to be made by an inspector appointed by it or an inspector of the department.
- Sec 1523 (a) The board is hereby empowered to execute the agreements provided in this act and to promulgate such regulations as they may deem necessary for this purpose. When any such agreement has been approved by the department, the same shall be properly filed and docketed, and the board

shall from time to time until such agreement shall be modified or terminated as provided in this act pay the sums therein agreed upon. All such payments shall be made by check of the State Treasurer issued upon requisition of the secretary. Every such check shall be mailed to the person or persons entitled thereto under such agreement. When any award is made by the Workers' Compensation Appeal Board or by a workers' compensation judge in any proceedings brought by an employe of a subscriber or the dependents of such employe against the fund, this award shall be filed and docketed, and the board shall from time to time until such award is modified, reversed or terminated pay the sums therein lawfully awarded against the fund. All such payments shall be made by check of the State Treasurer issued upon requisition of the secretary, and every such check shall be mailed to the person or persons entitled thereto under the award.

- (b) When any proceedings brought by an employe of a subscriber or the dependents of such employe against the fund for benefits payable under the Longshore and Harbor Workers' Compensation Act (44 Stat. 1424, 33 U.S.C. § 901 et seq.) or the Federal Coal Mine Health and Safety Act of 1969 (Public Law 91-173, 30 U.S.C. § 801 et seq.), such proceedings shall be filed and docketed; the board shall from time to time until such benefits are modified, reversed, or terminated pay such benefit sums for which the fund is legally responsible. All such payments shall be made by check of the State Treasurer issued upon requisition of the secretary, and every such check shall be mailed to the person or persons entitled thereto.
- (c) When any proceedings brought by an employe of a subscriber or the dependents of such employe against the fund for sums such subscriber shall become legally obligated to pay any employe of his as damages because of bodily injury by accident or disease, including death at any time resulting therefrom, sustained by such employe arising out of and in the course of his employment, such proceedings shall be filed and docketed, and the board shall from time to time until such damage sums are modified, reversed or terminated pay such damage sums for which the fund is legally responsible. All such payments shall be made by check the State Treasurer issued upon requisition of the secretary, and every such check shall be mailed to the person or persons entitled thereto.

Sec 1524 All salaries, wages, fees or other compensation of physicians, attorneys, investigators, assistants and other employes necessary for the proper administration of the fund and the proper conduct of the work of the board shall be paid out of the fund. All payments to employes, dependents of deceased employes, physicians, attorneys, investigators, assistants and others entitled to be paid out of the fund shall be made by the State Treasurer upon requisition of the secretary.

Sec 1525 Information acquired by the fund, its officers and employes from employers, employes or insurance corporations or associations shall not be open to public inspection.

- Sec 1526
- (a) The fund is authorized to provide to sole proprietors or partners engaged in logging or logging-related businesses coverage equivalent to that which the fund provides to employers which insure their liability under Article III. This coverage shall be provided in accordance with this article. In all cases where an injury which is compensable under the terms of this coverage is received by a sole proprietor or a partner engaged solely in logging or logging-related businesses, there is a rebuttable presumption that his wages shall be equal to fifty per centum of the Statewide average weekly wage for the purpose of computing his compensation under sections 306 and 307.
 - (b) For purposes of this section, "logging" or "logging-related business" means the cutting of trees, any skidding activity and the transportation of logs or raw lumber, including the construction, operation, maintenance and extension of logging roads or trails.

“THE PENNSYLVANIA OCCUPATIONAL DISEASE ACT”
Act of 1939, P.L. 566, No. 284

AN ACT

Defining the liability of an employer to pay damages for occupational disease contracted by an employe arising out of and in the course of employment; establishing an elective schedule of compensation; providing procedure for the determination of liability and compensation thereunder; imposing duties on the Department of Labor and Industry, the Workmen’s Compensation Board, Workmen’s Compensation Referees, and deans of medical schools; creating a medical board to determine controverted medical issues; establishing an Occupational Disease Fund in custody of the State Workmen’s Insurance Board; imposing upon the Commonwealth a part of the compensation payable for certain occupational diseases; making an appropriation; and prescribing penalties.

ARTICLE I
Interpretation and Definitions

- Sec 101 This act shall be called and may be cited as The Pennsylvania Occupational Disease Act. It shall apply to disabilities and deaths caused by occupational disease as defined in this act, resulting from employment within this Commonwealth, irrespective of the place where the contract of hiring was made, renewed, or extended, and shall not apply to any such disabilities and deaths resulting from employment outside of the Commonwealth.
- Sec 102 Wherever in this act the singular is used, the plural shall be included; and where the masculine gender is used, the feminine and neuter shall be included.
- Sec 103 The term “employer,” as used in this act, is declared to be synonymous with master, and to include natural persons, partnerships, joint-stock companies, corporations for profit, corporations not for profit, municipal corporations, the Commonwealth, and all governmental agencies created by it.
- Sec 104 The term “employe,” as used in this act, is declared to be synonymous with servant, and includes all natural persons who perform services, except agricultural services or domestic services performed in a private home, for another for a valuable consideration, exclusive of persons whose employment is casual in character and not in the regular course of the business of the employer and exclusive of persons to whom articles or materials are given out to be made up, cleaned, washed, altered, ornamented, finished or repaired, or adapted for sale, in the worker’s own home, or on other premises not under the control or management of the employer. Every executive officer of a corporation elected or appointed in accordance with the charter and by-laws of the corporation, except elected officers of the Commonwealth or any of its political subdivisions, shall be an employe of the corporation.
- Sec 105 The term “contractor,” as used in article two, section two hundred and three, and article three, section three hundred and two (b), shall not include a contractor engaged in an independent business, other than that of supplying laborers or assistants, in which he serves persons other than the employer in whose service the disability occurs, but shall include a subcontractor to whom a principal contractor has sublet any part of the work which such principal contractor has undertaken.
- Sec 106 The exercise and performance of the powers and duties of a local or other public authority shall, for the purposes of this act, be treated as the trade or business of the authority.
- Sec 107 The term “department,” when used in this act, shall mean the Department of Labor and Industry of this Commonwealth.

The term “board,” when used in this act, shall mean The Workmen’s Compensation Board of this Commonwealth.

The term “referee,” when used in this act, shall mean Workmen’s Compensation Referee.

Sec 108 The term “occupational disease,” as used in this act, shall mean only the following diseases:

- (a) Poisoning by arsenic, lead, mercury, manganese, or beryllium, their preparations or compounds, in any occupation involving direct contact with, handling thereof, or exposure thereto.
- (b) Poisoning by phosphorus, its preparations or compounds, in any occupation involving direct contact with, handling thereof, or exposure thereto.
- (c) Poisoning by methanol, carbon bisulphide, carbon monoxide, hydro carbon distillates (naphthas and others), or halogenated hydro carbons, or any preparations containing these chemicals or any of them, in any occupation involving direct contact with, handling thereof, or exposure thereto.
- (d) Poisoning by benzol, or by nitro, amido, or amino derivatives of benzol (dinitro-benzol, aniline, and others), or their preparations or compounds, in any occupation involving direct contact with, handling thereof, or exposure thereto.
- (e) Caisson disease (compressed air illness) resulting from engaging in any occupation carried on in compressed air.
- (f) Radium poisoning or disability, due to radioactive properties of substances or to Roentgen-ray (X-rays) in any occupation involving direct contact with, handling thereof, or exposure thereto.
- (g) Poisoning by, or ulceration from, chromic acid, or bichromate of ammonium, bichromate of potassium, or bichromate of sodium, or their preparations, in any occupation involving direct contact with, handling thereof, or exposure thereto.
- (h) Epitheliomatous cancer or ulceration due to tar, pitch, bitumen, mineral oil, or paraffin, or any compound, product or residue of any of those substances, in any occupation involving direct contact with, handling thereof, or exposure thereto.
- (i) Infection or inflammation of the skin due to oils, cutting compounds, lubricants, dust, liquids, fumes, gases, or vapor, in any occupation involving direct contact with, handling thereof, or exposure thereto.
- (j) Anthrax occurring in any occupation involving the handling of or exposure to wool, hair, bristles, hides, or skins, or bodies of animals either alive or dead.
- (k) Silicosis, anthraco-silicosis or coal worker’s pneumoconiosis (the latter two commonly know as Miner’s Asthma and hereinafter referred to as anthraco-silicosis or coal worker’s pneumoconiosis) in any occupation involving direct contact with, handling of, or exposure to the dust of anthracite or bituminous coal and/or dust of silicon dioxide (SiO₂).
- (l) Asbestosis in any occupation involving direct contact with, handling of, or exposure to the dust of asbestos.
- (m) Tuberculosis, serum hepatitis or infectious hepatitis in the occupation of nursing or auxiliary services involving exposure to such disease.
- (n) All other occupational diseases (1) to which the claimant is exposed by reason of this employment, and (2) which are peculiar to the industry or occupation, and (3) which are not common to the general population. For the purposes of this clause, partial loss of hearing due to noise shall not be considered an occupational disease.

- (o) Diseases of the heart and lungs, resulting in either temporary or permanent total or partial disability or death, after four years or more of service in fire fighting for the benefit or safety of the public, caused by extreme over-exertion in times of stress or danger or by exposure to heat, smoke, fumes or gases, arising directly out of the employment of any such firemen. The Commonwealth shall pay the full amount of compensation for disability under this clause.

Sec 109 No compensation shall be paid for any occupational disease if, during hostile attacks on the United States, disability or death of an employe results solely from military activities of the armed forces of the United States or from military activities or enemy sabotage of a foreign power.

ARTICLE II
Damages by Action at Law

- Sec 201 In any action brought to recover damages for disability or death of an employe caused by occupational disease arising out of and in the course of his employment, it shall not be a defense that the occupational disease was caused in whole or in part by the negligence of a fellow employe.
- Sec 202 The employer shall be liable for the negligence of employes other than the plaintiff, while acting within the scope of their employment, including engineers, chauffeurs, miners, mine-foremen, fire-bosses, mine superintendents, plumbers, officers of vessels, and all other employes licensed by the Commonwealth or other governmental authority, if the employer be allowed by law the right of free selection of such employes from the class of persons thus licensed; and such employes shall be the agents and representatives of their employers, and their employers shall be responsible for the acts and neglects of such employes, as in the case of other agents and employes of their employers; and, notwithstanding the employment of such employes, the property in and about which they are employed, and the use and operation thereof, shall at all times be under the supervision, management and control of their employers.
- Sec 203 An employer who permits the entry upon premises occupied by him or under his control of a laborer or an assistant hired by an employe or contractor who has rejected article three of this act, for the performance upon such premises of a part of the employer's regular business entrusted to such employe or contractor, shall be liable to such laborer or assistant in the same manner and to the same extent as to his own employe.
- Sec 204 No agreement, composition, or release of damages made before the date of any disability or death resulting from occupational disease, except the agreement defined in article three of this act, shall be valid or shall bar a claim for damages for such disability or death; and any such agreement other than that defined in article three herein, is declared to be against the public policy of this Commonwealth. The receipt of benefits from any association, society, or fund shall not bar the recovery of damages by action at law, nor the recovery of compensation under article three hereof; and any release executed in consideration of such benefits shall be void: Provided, however, That if the employe receives unemployment compensation benefits, such amount or amounts so received shall be credited as against the amount of the award made under the provisions of the occupational disease act.
- Sec 205 If disability or death is compensable under this act, a person shall not be liable to anyone at common law or otherwise on account of such disability or death for any act or omission occurring while such person was in the same employ as the person disabled or killed, except for intentional wrong.

ARTICLE III
Elective Compensation

- Sec 301 (a) When employer and employe shall by agreement, either express or implied, as hereinafter provided, accept the provisions of article three of this act, compensation for disability or death of such employe, caused by occupational disease, arising out of and in the course of his employment, shall be paid by the employer, without regard to negligence, according to the schedule contained in sections three hundred and six and three hundred and seven of this article, but —
- (1) No compensation shall be paid when the disability or death is caused by the employe's violation of law, but the burden of proof of such fact shall be upon the employer.
 - (2) The maximum compensation payable under this article for disability, and death resulting from silicosis, anthraco-silicosis, coal worker's pneumoconiosis, or asbestosis shall not exceed the sum of twelve thousand seven hundred fifty dollars (\$12,750) which shall be full and complete payment for all disability, present or future, or for death from such occupational diseases arising out of employment by any and all employers in this Commonwealth except that any employe who has received the maximum compensation herein or heretofore payable shall be paid additional compensation in the amount of seventy-five dollars (\$75) per month for each month of total disability occurring subsequent to the month in which such maximum compensation was received: Provided, That in the case of any employe who received the maximum compensation herein or heretofore payable prior to the effective date of this amending act, such additional compensation shall commence only with the month this amending act becomes effective. Such additional compensation which is paid to an employe who, on the effective date of this amending act, is receiving compensation or has theretofore received the maximum compensation prescribed, shall be paid by the Commonwealth. Such additional compensation paid to an employe who first becomes entitled to compensation subsequent to the effective date of this amending act and who exhausts the maximum compensation prescribed, shall be paid from the same source or sources and in the same manner as the prescribed maximum compensation was paid.
- (b) The right to receive compensation under this act shall not be affected by the fact that a minor is employed or is permitted to be employed in violation of the laws of this Commonwealth relating to the employment of minors, or that he obtained his employment by misrepresenting his age.
- (c) Compensation for the occupational diseases enumerated in this act shall be paid only when such occupational disease is peculiar to the occupation or industry in which the employe was engaged and not common to the general population. Wherever compensable disability or death is mentioned as a cause for compensation under this act, it shall mean only compensable disability or death resulting from occupational disease and occurring within four years after the date of his last employment in such occupation or industry.
- (d) Compensation for silicosis, or anthraco-silicosis, coal worker's pneumoconiosis and asbestosis, shall be paid only when it is shown that the employe has had an aggregate employment of at least two years in the Commonwealth of Pennsylvania, during a period of ten years next preceding the date of disability, in an occupation having a silica, coal or asbestos hazard.
- (e) Compensation shall not be payable for partial disability due to silicosis, anthraco-silicosis, coal worker's pneumoconiosis, or asbestosis. Compensation shall be payable, as otherwise provided in this act, for total disability or death caused by silicosis, anthraco-silicosis, coal worker's pneumoconiosis, or asbestosis, or by silicosis, anthraco-silicosis, coal worker's pneumoconiosis, or asbestosis, when accompanied by active pulmonary tuberculosis.
- (f) If it be shown that the employe, at or immediately before the date of disability, was employed in any occupation or industry in which the occupational disease is a hazard, it shall be presumed that

the employee's occupational disease arose out of and in the course of his employment, but this presumption shall not be conclusive.

- (g) The employer liable for the compensation provided by this article shall be the employer in whose employment the employe was last exposed to the hazard of the occupational disease claimed, regardless of the length of time of such last exposure: Provided, That when a claimant alleges that disability or death was due to silicosis, anthraco-silicosis, coal worker's pneumoconiosis, asbestosis or any other occupational disease which developed to the point of disablement only after an exposure of five or more years, the only employer liable shall be the last employer in whose employment the employe was last exposed to the hazard of such occupational disease during a period of six months or more: And provided further, That in those cases where disability or death is not conclusively proven to be the result of such last exposure, all compensation shall be paid by the Commonwealth. An exposure during a period of less than six months after the effective date of this act shall not be deemed an exposure. The notice of disability or death and claim shall be made to the employer who is liable under this subsection, his insurance carrier, if any, and the Commonwealth.
- (h) Except as hereinafter provided, all compensation payable under this article shall be payable in periodic installments, as the wages of the employe were payable before the accident.
- (i) Notwithstanding any other provisions of this act, compensation for silicosis, anthraco-silicosis, coal worker's pneumoconiosis, and asbestosis shall be paid for each month beginning with the month this amending act becomes effective, or beginning with the first month of disability, whichever occurs later, at the rate of seventy-five dollars (\$75) per month, to every employe totally disabled thereby as a result of exposure thereto, who has not theretofore been compensated because his claim was barred by any of the time limitations prescribed by this act, and shall continue during the period of such total disability. No compensation under this section shall be paid to any employe who has not been exposed to a silica, coal, or asbestos hazard within the Commonwealth of Pennsylvania for a period of two years. Subsequent to the effective date of this amending act of 1969, it shall be necessary to be a resident of Pennsylvania in order to qualify for compensation, but not to continue receiving the same after qualification. All such compensation to those whose last exposure precedes the effective date of this amending act shall be paid by the Commonwealth. Employes whose last exposure follows the effective date of this amending act and who become entitled to the compensation provided by this subsection shall be paid as provided by this act.

An application for compensation under this subsection shall not be accepted from any person who, during the preceding six months has been determined to be ineligible hereunder.

Every application shall be accompanied by two prints of the same recent photograph of the applicant, and such other proof of identity as the board shall require. One of the prints shall be stamped by the board and returned to the applicant, who shall deliver it to the physician at the time of examination. The physician shall attach the print to his report to the board.

- (j) Every person heretofore or hereafter qualified for additional compensation under the provisions of clause 2 of subsection (a) or subsection (i) of this section shall, beginning with the month following the effective date of this amending act of 1969, or the month of qualification, whichever occurs later, be paid further compensation of twenty-five dollars (\$25) per month during the period of disability. Such further compensation paid to a person heretofore qualified shall be paid by the Commonwealth. Compensation paid to any person hereafter qualified shall be paid from the same source as the additional compensation provided in clause 2 of subsection (a) or subsection (i) of this section.
- (k) Upon the award of any benefits under the Federal Coal Mine Health and Safety Act of 1969 to a person who is also receiving or claiming monthly compensation totally funded by general revenues

of the Commonwealth of Pennsylvania under subsections (a), (i), (j), or (l) of section 301, such person shall have his monthly compensation from general revenues of the Commonwealth suspended effective with the month following the month of award of Federal benefits, as may be evidenced by a copy of the Federal award certificate, or effective with the month of enactment of this amendment, whichever is later. Upon any future action by the United States Congress, Federal executive departments, or Federal courts which would make present recipients under the Pennsylvania Occupational Disease Act eligible for both Federal and State payments, the sum of which would exceed the maximum authorized Federal payment, the eligible recipients would then receive retroactively all State payments that were suspended under the authority of this act. All such recipients who have their State payments suspended shall continue their eligibility and entitlement under the Pennsylvania Occupational Disease Act and at any time in the future for whatever reason that such recipients' payments under the Federal law are terminated, suspended or reduced their State payments shall be reinstated effective with the month following the month that Federal benefits are terminated, suspended or reduced. The recipients' entitlement to weekly compensation and the maximum sum thereof provided under clause 2 of subsection (a) of section 301 shall remain unchanged, and no reduction shall be made in the medical and hospital compensation payable under subsection (f) of section 306 or in the burial expenses payable under clause 8 of section 307.

- (l) Every person heretofore or hereafter qualified for additional compensation under the provisions of clause (2) of subsection (a) or subsection (i) shall, beginning with the month following the effective date of this amending act, or the month of qualification, whichever occurs later, be paid further compensation of twenty-five dollars (\$25) per month during the period of disability. Such further compensation paid to a person heretofore or hereafter qualified shall be paid by the Commonwealth.

Sec 302

- (a) In every contract of hiring made after October first, one thousand nine hundred and thirty-nine, and in every contract of hiring renewed or extended by mutual consent, expressed or implied, after said date, it shall be conclusively presumed that the parties have accepted the provisions of article three of this act, and have agreed to be bound thereby, unless the employer shall post at this plant, office or place of business a notice of his intention not to pay such compensation or unless there be, at the time of the making, renewal, or extension of such contract, an express statement in writing, from either party to the other, that the provisions of article three of this act are not intended to apply, and unless a true copy of such posted notice or such written statement, accompanied by proof of posting or proof of service thereof upon the other party, setting forth under oath or affirmation the time, place, and manner of such posting or service, be filed with the department within twenty days after such posting or service. Every contract of hiring, oral, written, or implied from circumstances, now in operation, or made or implied on or before October first, one thousand nine hundred and thirty-nine, shall be conclusively presumed to continue subject to the provisions of article three hereof, unless the employer shall on or before said date either post at his plant, office or place of business a notice of his intention not to pay such compensation or unless either party shall, on or before said date, in writing, have notified the other party to such contract that the provisions of article three hereof are not intended to apply, and unless there shall be filed with the department a true copy of such notice, together with proof of posting or service, within the time and in the manner hereinabove prescribed: Provided, however, That the provisions of this section shall not be so construed as to impair the obligation of any contract now in force. Such posted notice shall constitute sufficient notice to all employes and to the parents and guardians of all minor employes, and a certified copy of proof of posting or proof of service shall be prima facie evidence of notice. It shall not be lawful for any officer or agent of this Commonwealth, or for any county, city, borough, town, or township therein, or for any officer or agent thereof, or for any other governmental authority created by the laws of this Commonwealth, to give such notice of rejection of the provisions of this article to any employe of the Commonwealth or of such governmental agency.
- (b) After October first, one thousand nine hundred and thirty-nine, an employer who permits the entry, upon premises occupied by him or under his control, of a laborer or an assistant hired by an

employe or contractor, for the performance upon such premises of a part of the employer's regular business entrusted to that employe or contractor, shall be conclusively presumed to have agreed to pay to such laborer or assistant compensation in accordance with the provisions of article three, unless the employer shall post at his plant, office or place of business a notice of his intention not to pay such compensation, and unless there be filed with the department within twenty days, thereafter, a true copy of such notice, together with proof of the posting of the same, setting forth upon oath or affirmation the time, place, and manner of such posting; and after October first, one thousand nine hundred and thirty-nine, any such laborer or assistant who shall enter upon premises occupied by or under control of such employer, for the purpose of doing such work, shall be conclusively presumed to have agreed to accept the compensation provided in article three, in lieu of his right of action under article two, unless he shall have given notice in writing to the employer, at the time of entering upon such employer's premises for the purpose of doing his work, of his intention not to accept such compensation, and unless within twenty days thereafter there shall have been filed with the department a true copy of such notice, accompanied by proof of service thereof upon such employer, setting forth under oath or affirmation the time, place, and manner of such service. And in such cases where article three binds such employer and such laborer or assistant, it shall not be in effect between the intermediate employer or contractor and such laborer or assistant, unless otherwise expressly agreed.

- (c) Any notice given hereunder by an employer to his employes need not be addressed to each employe individually, but may be addressed to all employes. Proof of service of any number of statements or notices may be made in one affidavit, but such affidavit shall state the time and place of each service.

Sec 303 Such agreement shall constitute an acceptance of all the provisions of article three of this act, and shall operate as a surrender by the parties thereto of their rights to any form or amount of compensation or damages for any disability or death resulting from occupational disease, or to any method of determination thereof, other than as provided in article three of this act. Such agreement shall bind the employer and his personal representatives, and the employe, his or her wife, or husband, widow or widower, next of kin, and other dependents.

Sec 304 Any agreement between employer and employe for the operation or nonoperation of the provisions of article three of this act may be terminated by the posting of notice by the employer or by either party upon thirty days' notice to the other in writing, if a copy of such notice, with proof of posting or proof of service, be filed in the department as provided in section three hundred and two of this article.

Sec 304.1 The Secretary of Labor and Industry shall, within ninety (90) days after the effective date of this amendatory act, prepare a brochure of instructions, setting forth the rights of an employe in the event of disability or death caused by occupational disease and informing him of the time and manner in which claims should be filed. A copy of such brochure shall be provided to each insurance company authorized to write insurance policies covering occupational diseases under this act. Such insurance companies shall prepare at their own expense copies of said brochure for distribution to such insured employers. Each insurance company shall prepare the brochures immediately upon receipt of the sample brochure from the Secretary of Labor and Industry in such quantity as required by employers for distribution to each employe. The employer shall distribute such brochures to each employe at the time of hiring and to each existing employe within thirty (30) days after the receipt of the brochure.

Sec 305 Every employer liable under this act to pay compensation shall insure the payment of compensation in the State Workmen's Insurance Fund, or in any insurance company, or mutual association or company, authorized to insure such liability in this Commonwealth, unless such employer shall be exempted by the department from such insurance. Such insurer shall assume the employer's liability hereunder and shall be entitled to all of the employer's immunities and protection hereunder except, that whenever any employer shall have purchased insurance to provide benefits under this act to persons excluded from the definition of "employe" under section 104 of this act by virtue of being engaged in domestic service or agriculture, neither the employer nor the insurer shall be entitled to raise the defense of such exclusion.

An employer desiring to be exempt from insuring the whole or any part of his liability for compensation shall make application to the department, showing his financial ability to pay such compensation, whereupon the department, if the applicant establishes his financial ability, shall issue to the applicant a permit authorizing such exemption. The department shall establish a period of twelve calendar months, to begin and end at such times as the department shall prescribe, which shall be known as the annual exemption period. Unless previously revoked, all permits issued under this section shall expire and terminate on the last day of the annual exemption period for which they were issued. Permits issued under this act shall be renewed upon the filing of an application. The department may, from time to time, require further statements of the financial ability of such employer, and, if at any time such employer appears no longer able to pay compensation, shall revoke its permit granting exemption, in which case the employer shall immediately subscribe to the State Workmen's Insurance Fund or insure his liability in any insurance company or mutual association or company, as aforesaid.

Any employer who fails to comply with the provisions of this section for every such failure shall, upon summary conviction before any official of competent jurisdiction, be sentenced to pay a fine of not less than one hundred dollars or more than five hundred dollars, and costs of prosecution, or imprisonment for a period of not more than six months, or both. Every day's violation shall constitute a separate offense. It shall be the duty of the department to enforce the provisions of this section; and it shall investigate all violations that are brought to its notice and shall institute prosecutions for violations thereof. All fines recovered under the provisions of this section shall be paid to the department and by it paid into the State Treasury.

Sec 306 The following schedule of compensation is hereby established subject to the limitations of section 301:

- (a) For total disability, sixty-six and two-thirds per centum of the wages of the disabled employe as defined in section three hundred and nine, beginning after the seventh day of total disability, and payable for the duration of total disability, but the compensation shall not be more than sixty dollars per week nor less than thirty-five dollars per week. If at the time when disability begins, the employe receives wages of thirty-five dollars per week or less, then he shall receive ninety per centum of the wages per week as compensation, but in no event less than twenty-two dollars per week. Nothing in this clause shall require payment of compensation after disability shall cease.
- (b) For disability partial in character (except the particular cases mentioned in clause (c)) sixty-six and two-thirds per centum of the difference between the wages of the disabled employe, as defined in section three hundred and nine, and the earning power of the employe thereafter; but such compensation shall not be more than forty-five dollars per week. This compensation shall be paid during the period of such partial disability except as provided in clause (e) of this section, but not more than three hundred and fifty weeks. Should total disability be followed by partial disability, the period of three hundred and fifty weeks shall not be reduced by the number of weeks during which compensation was paid for total disability. The term "earning power," as used in this section, shall in no case be less than the weekly amount which the employe receives after disability begins, and in those cases in which the employe works fewer than five days per week for reasons not connected with or arising out of the disability resulting from the injury shall not be less than five times his actual daily wage as fixed by the day, hour, or by the output of the employe, and in no instance shall an employe receiving compensation under this section receive more in compensation and wages combined than a fellow employe in employment similar to that in which the injured employe was engaged at the time of disability.
- (c) For all disability resulting from loss or loss of the use of members resulting from occupational disease, the compensation shall be exclusively as follows:

For the loss of a hand, sixty-six and two-thirds per centum of wages during one hundred and seventy-five weeks.

For the loss of a forearm, sixty-six and two-thirds per centum of wages during one hundred and ninety-five weeks.

For the loss of an arm, sixty-six and two-thirds per centum of wages during two hundred and fifteen weeks.

For the loss of a foot, sixty-six and two-thirds per centum of wages during one hundred and fifty weeks.

For the loss of a lower leg, sixty-six and two-thirds per centum of wages during one hundred and eighty weeks.

For the loss of a leg, sixty-six and two-thirds per centum of wages during two hundred and fifteen weeks.

For the loss of an eye, sixty-six and two-thirds per centum of wages during one hundred and fifty weeks.

For the complete loss of hearing in both ears, sixty-six and two-thirds per centum of wages during one hundred and eighty weeks.

For the loss of a thumb, sixty-six and two-thirds per centum of wages during sixty weeks.

For the loss of a first finger, commonly called index finger, sixty-six and two-thirds per centum of wages during thirty-five weeks.

For the loss of a second finger, sixty-six and two-thirds per centum of wages during thirty weeks.

For the loss of a third finger, sixty-six and two-thirds per centum of wages during twenty weeks.

For the loss of a fourth finger, commonly called little finger, sixty-six and two-thirds per centum of wages during fifteen weeks.

The loss of the first phalange of the thumb shall be considered the loss of the thumb. The loss of a substantial part of the first phalange of the thumb shall be considered the loss of one-half of the thumb.

The loss of any substantial part of the first phalange of a finger, or an amputation immediately below the first phalange for the purpose of providing an optimum surgical result, shall be considered the loss of one-half of the finger. Any greater loss shall be considered the loss of the entire finger.

The loss of one-half of the thumb or a finger shall be compensated at the same rate as for the loss of a thumb or finger, but for one-half of the period provided for the loss of a thumb or finger.

For the loss of, or permanent loss of the use of, any two or more such members, not constituting total disability, sixty-six and two-thirds per centum of wages during the aggregate of the periods specified for each.

For the loss of a great toe, sixty-six and two-thirds per centum of wages during forty weeks.

For the loss of any other toe, sixty-six and two-thirds per centum of wages during sixteen weeks.

The loss of the first phalange of the great toe, or of any toe, shall be considered equivalent to the loss of one-half of such great toe, or other toe, and shall be compensated at the same rate as for the loss of a great toe, or other toe, but for one-half of the period provided for the loss of a great toe or other toe.

The loss of more than one phalange of a great toe, or any toe, shall be considered equivalent to the loss of the entire great toe or other toe.

For the loss of, or permanent loss of the use of any two or more such members, not constituting total disability, sixty-six and two-thirds per centum of wages during the aggregate of the periods specified for each.

Unless the board shall otherwise determine, the loss of both hands or both arms or both feet or both legs or both eyes shall constitute total disability, to be compensated according to the provisions of clause (a).

Amputation at the wrist shall be considered as the equivalent of the loss of a hand, and amputation at the ankle shall be considered as the equivalent of the loss of a foot. Amputation between the wrist and the elbow shall be considered as the loss of a forearm, and amputation between the ankle and the knee shall be considered as the loss of a lower leg. Amputation at or above the elbow shall be considered as the loss of an arm and amputation at or above the knee shall be considered as the loss of a leg. Permanent loss of the use of a hand, arm, foot, leg, eye, finger, or thumb, great toe or other toe, shall be considered as the equivalent of the loss of such hand, arm, foot, leg, eye, finger, or thumb, great toe or other toe.

In addition to the payments hereinbefore provided for disabilities of the classes specified, any period of disability necessary and required as a healing period shall be compensated in accordance with the provisions of this subsection. The healing period shall end (I) when the claimant returns to employment without impairment in earnings, or (II) on the last day of the period specified in the following table, whichever is the earlier:

For the loss of a hand, twenty weeks.

For the loss of a forearm, twenty weeks.

For the loss of an arm, twenty weeks.

For the loss of a foot, twenty-five weeks.

For the loss of the lower leg, twenty-five weeks.

For the loss of a leg, twenty-five weeks.

For the loss of an eye, ten weeks.

For the loss of hearing, ten weeks.

For the loss of a thumb or any part thereof, ten weeks.

For the loss of any other finger or any part thereof, six weeks.

For the loss of a great toe or any part thereof, twelve weeks.

For the loss of any other toe or any part thereof, six weeks.

This compensation shall not be more than sixty dollars per week nor less than thirty-five dollars per week: Provided, That if at the time of disability the employe receives wages of thirty-five dollars per week or less, then he shall receive ninety per centum of such wages per week as compensation, but in no event less than twenty-two dollars per week. When an employe works during the healing period, his wages and earning power shall be as defined in this act, and he shall not receive more in wages and compensation combined than his wages at the time of disability as defined in section 309. Where any such injury or injuries shall require an amputation at a time after the end of the healing period hereinbefore provided, the employe shall be entitled to receive compensation for the second healing period, and in the case of a second injury or amputation to the

same limb prior to the expiration of their first healing period, a new healing period shall commence for the period hereinbefore provided and no further compensation shall be payable for the first healing period.

- (d) Where, at the time of disability, the employe incurs other disabilities, separate from those which result in permanent disabilities enumerated in clause (c) of this section, the number of weeks for which compensation is specified for the permanent disabilities shall begin at the end of the period of temporary total disability which results from the other separate disability, but in that event the employe shall not receive compensation provided in clause (c) of this section for the specific healing period. In the event the employe incurs two or more permanent disabilities of the above enumerated classes compensable under clause (c) of this section, he shall be compensated for the largest single healing period rather than the aggregate of the healing periods.
- (e) No compensation shall be allowed for the first seven days after disability begins, except as provided in this clause (e) and clause (f) of this section. If the period of disability lasts more than six weeks after disability begins, the employe shall also receive compensation for the first seven days of disability.
- (f) During the first six months after disability begins, the employer shall furnish reasonable surgical and medical services, medicines, and supplies, as and when needed, unless the employe refuses to allow them to be furnished by the employer. The cost of such services, medicines, and supplies, shall not exceed seven hundred fifty dollars. If the employer shall, upon application made to him, refuse to furnish such services, medicines, and supplies, the employe may procure same and shall receive from the employer the reasonable cost thereof within the above limitations. In addition to the above service, medicines, and supplies, hospital treatment, services, and supplies and orthopedic appliances and prostheses, shall be furnished by the employer for the said period of six months. The board may order further medical, surgical and hospital services if it is established that further care will result in restoring the disabled employe's earning power to a substantial degree. In each order the board shall specify the maximum period and the maximum costs of the treatment designed for the employe's rehabilitation. The cost of such hospital treatment, service, and supplies, shall not in any case exceed the prevailing charge in the hospital for like services to other individuals. If the employe shall refuse reasonable surgical, medical, and hospital services, medicines, and supplies, tendered to him by his employer, he shall forfeit all rights to compensation for disability or any increase in his disability shown to have resulted from such refusal. Whenever an employe shall have suffered the loss of a limb, part of a limb, or an eye, the employer shall furnish to the employe in addition to the aforementioned surgical and medical services, services rendered by duly licensed practitioners of the healing arts, medicines and supplies, or artificial limb or eye or other prostheses of a type and kind recommended by the doctor attending such employe in connection with such injury as well as such training as may be required in the proper use of such prostheses. The provisions of this section shall apply to occupational diseases where no loss of earning power occurs.
- (g) Should the employe die from some other cause than the occupational disease, the liability for compensation shall cease.

Sec 307 In case of death resulting from occupational disease, compensation shall be computed on the following basis, and distributed to the following persons, subject to the limitations of section 301:

- 1. If there be no widow nor widower entitled to compensation, compensation shall be paid to the guardian of the child or children, or if there be no guardian, to such other persons as may be designated by the board as hereinafter provided, as follows:
 - (a) If there be one child, thirty-two per centum of wages of deceased, but not in excess of twenty-five dollars per week.
 - (b) If there be two children, forty-two per centum of wages of deceased, but not in excess of thirty-three dollars per week.

- (c) If there be three children, fifty-two per centum of wages of deceased, but not in excess of forty-one dollars per week.
 - (d) If there be four children, sixty-two per centum of wages of deceased, but not in excess of forty-eight dollars per week.
 - (e) If there be five children, sixty-four per centum of wages of deceased, but not in excess of fifty-four dollars per week.
 - (f) If there be six or more children, sixty-six and two-thirds per centum of wages of deceased, but not in excess of sixty dollars per week.
2. To the widow or widower, if there be no children, fifty-one per centum of wages, but not in excess of thirty-nine dollars per week.
 3. To the widow or widower, if there be one child, sixty per centum of wages, but not in excess of forty-six dollars per week.
 4. To the widow or widower, if there be two children, sixty-six and two-thirds per centum of wages but not in excess of fifty-four dollars per week.
 5. To the widow or widower, if there be three or more children, sixty-six and two thirds per centum of wages, but not in excess of sixty dollars per week.
 6. If there be neither widow, widower, nor children, entitled to compensation, then to the father or mother, if dependent to any extent upon the employe at the time of his death, thirty-two per centum of wages, but not in excess of twenty-five dollars per week: Provided, however, That in the case of a minor child who has been contributing to his parents, the dependency of said parents shall be presumed: And provided further, That if the father and mother was totally dependent upon the deceased employe at the time of his death, the compensation payable to such father or mother shall be fifty-two per centum of wages, but not in excess of thirty-eight dollars per week.
 7. If there be neither widow, widower, children, nor dependent parent, entitled to compensation, then to the brothers and sisters, if actually dependent upon the decedent for support at the time of his death, twenty-two per centum of wages for one brother or sister, and five per centum additional for each additional brother or sister, with a maximum of thirty-two per centum, such compensation to be paid to their guardian, or, if there be no guardian, to such other person as may be designated by the board, as hereinafter provided.
 8. Whether or not there be dependents as aforesaid, the reasonable expense of burial, not exceeding seven hundred fifty dollars, which shall be paid by the employer or insurer directly to the undertaker (without deduction of any amounts theretofore paid for compensation or for medical expenses).

Compensation shall be payable under this section to or on account of any child, brother, or sister, only if and while such child, brother, or sister is under the age of eighteen. No compensation shall be payable under this section to a widow, unless she was living with her deceased husband at the time of his death, or was then actually dependent upon him and receiving from him a substantial portion of her support. No compensation shall be payable under this section to a widower, unless he be incapable of self-support at the time of his wife's death and be at such time dependent upon her for support. If members of decedent's household at the time of his death, the terms "child" and "children" shall include stepchildren, adopted children and children to whom he stood in loco parentis, and shall include posthumous children. Should any dependent of a deceased employe die or remarry, or should the widower become capable of self-support, the right of such dependent or widower to compensation under this section shall cease: Provided, however, That if, upon inves-

tigation and hearing, it shall be ascertained that the widow or widower is living with a man or woman, as the case may be, in meretricious relationship and not married, or the widow living a life of prostitution, the board may order the termination of compensation payable to such widow or widower. If the compensation payable under this section to any person shall for any cause, cease, the compensation to the remaining persons entitled thereunder shall thereafter be the same as would have been payable to them had they been the only persons entitled to compensation at the time of the death of the deceased.

The wages upon which death compensation shall be based shall not in any case be taken to exceed ninety dollars per week, nor be less than fifty dollars per week.

The board may, if the best interests of a child or children shall so require, at any time order and direct the compensation payable to a child or children, or to a widow or widower, on account of any child or children, to be paid to the guardian of such child or children, or, if there be no guardian, to such other person as the board, as hereinafter provided, may direct. If there be no guardian or committee of any minor, dependent, or insane employe, or dependent, on whose account compensation is payable, the amount payable on account of such minor, dependent, or insane employe, or dependent may be paid to any surviving parent, or to such other person as the board may order and direct, and the board may require any person, other than a guardian or committee, to whom it has directed compensation for a minor, dependent, or insane employe, or dependent to be paid, to render, as and when it shall so order, accounts of the receipts and disbursements of such person, and to file with it a satisfactory bond in a sum sufficient to secure the proper application of the moneys received by such person.

- Sec 308
- (a) When compensation is awarded because of disability or death caused by silicosis, anthraco-silicosis, coal worker's pneumoconiosis, asbestosis, or any other occupational disease which developed to the point of disablement only after an exposure of five or more years, the compensation for disability or death due to such disease shall, except as otherwise provided in subsection (g) of section 301, be paid jointly by the employer and the Commonwealth and the employer shall be liable for sixty per centum of the compensation due and the Commonwealth forty per centum.
 - (b) Compensation payable by the Commonwealth under subsection (a) of this section shall be paid out of appropriations made from time to time to the department out of the General Fund in the State Treasury.
 - (c) In all claims for compensation partially payable by the Commonwealth under subsection (a) of this section, the department shall be designated as a codefendant.
 - (d) In all agreements for the payment of compensation and all awards, the amount payable by the employer and the amount payable by the Commonwealth shall be separately stated. An award against the employer shall be for only the percentage of the total compensation which the employer is obligated to pay under subsection (a) of this section, not to exceed the stated percentage of the maximum payable by the employer under section 301 (a) 2 of this act, or if section 301(a) 2 be inapplicable, then under sections 306 and 307 of this act. A separate award shall be made against the Commonwealth for the balance of the compensation payable under said sections, which shall be payable out of appropriations made as aforesaid. Nothing in this section shall prohibit the Commonwealth from entering into agreements to pay the compensation for which it is liable: Provided, however, That where compensation is payable under the provisions of subsection (a) of this section, the Commonwealth shall not enter into an agreement unless the employer is a party to the agreement: And, provided further, That any such agreement shall contain facts sufficient to entitle the claimant to compensation and shall be accompanied by a supporting medical certificate. All such agreements shall be approved by the board or by a referee.

Sec 309 Whenever in this article the term "wages" is used, it shall be construed to mean the average weekly wages of the employe, ascertained as follows:

- (a) If at the time of the disability the wages are fixed by the week, the amount so fixed shall be the average weekly wage.
- (b) If at the time of the disability the wages are fixed by the month, the average weekly wage shall be the monthly wage so fixed, multiplied by twelve and divided by fifty-two.
- (c) If at the time of the disability the wages are fixed by the year, the average weekly wage shall be the yearly wage so fixed, divided by fifty-two.
- (d) If at the time of the disability the wages are fixed by the day, hour, or by the output of the employe, the average weekly wage shall be the wage most favorable to the employe, computed by dividing by thirteen the total wages of said employe earned in the employ of the employer in the first, second, third, or fourth period of thirteen consecutive calendar weeks in case the employe receives wages monthly or semi-monthly, by dividing by thirteen the total wages of said employe earned in the employ of the employer in the first, second, third, or fourth period of three consecutive calendar months in the year immediately preceding the disability.

If the employe has been in the employ of employer less than thirteen calendar weeks, (or three calendar months if the employe receives wages monthly, or semi-monthly) immediately preceding the disability, his average weekly wage shall be computed under the foregoing paragraph, taking "total wages" for such purpose to be the amount he would have earned had he been so employed by employer the full thirteen calendar weeks, (or three calendar months) immediately preceding the disability, and had worked when work was available to other employes in a similar occupation, unless it be conclusively shown that, by reason of exceptional causes, such method of computation does not ascertain fairly the "total wages" of the employe so employed less than thirteen calendar weeks (or three calendar months).

- (e) In occupations which are exclusively seasonal, and therefore cannot be carried on throughout the year, the average weekly wage shall be taken to be one-fiftieth of the total wages which the employe has earned from all occupations during the twelve calendar months immediately preceding the disability, unless it be shown that during such year, by reason of exceptional causes, such method of computation does not ascertain fairly the earnings of the employe, in which case the period for calculation shall be extended so far as to give a basis for the fair ascertainment of his average weekly earnings.

The terms "average weekly wage" and "total wages," as used in this section, shall include board and lodging received from the employer, and when so received, the board shall be rated at two dollars per day if more than one meal is served, and one dollar per day if only one meal is served, and lodging shall be rated at one dollar and fifty cents per day. In employments in which employes customarily receive not less than one-third of their remuneration in tips or gratuities not paid by the employer, gratuities shall be added to the wages received at the rate of two dollars per day; but such terms shall not include amounts deducted by the employer under the contract of hiring for labor furnished, or paid for by the employer, and necessary for the performance of such contract by the employe; nor shall such terms include deductions from wages due the employer for rent, and supplies necessary for the employe's use in the performance of his labor.

Where the employe is working under concurrent contracts with two or more employers, and the defendant employer has knowledge of such employment prior to the disability, his wages from all such employers shall be considered as if earned from the employer liable for compensation.

If under clauses (a), (b), (c), (d) and (e) of this section the amount determined is less than if computed as follows, this computation shall apply, via: divide the total wages earned by the employe during the last two completed calendar quarters with the same employer by the number of days he worked for such employer during such period multiplied by five.

The weekly wage upon which compensation shall be computed, shall be the wage earned by the employe in his last employment in the occupation or industry in which the occupational disease is a hazard.

Sec 310 Alien widows, children and parents, not residents of the United States, shall be entitled to compensation, but only to the amount of fifty per centum of the compensation which would have been payable if they were residents of the United States: Provided, That compensation benefits are granted residents of the United States under the laws of the foreign country in which the widow, children or parents reside. Alien widowers, brothers and sisters who are not residents of the United States shall not be entitled to receive any compensation. In no event shall any nonresident alien widow or parent be entitled to compensation in the absence of proof that the alien widow or parent has actually been receiving a substantial portion of his or her support from the decedent. Where transmission of funds in payment of any such compensation is prohibited by any law of the Commonwealth or of the United States to residents of such foreign country, then no compensation shall accrue or be payable while such prohibition remains in effect and, unless such prohibition is removed within six years from the date of death, all obligation to pay compensation under this section shall be forever extinguished.

In every instance where an award is made to alien widows, children or parents, not residents in the United States, the referee or the board shall, in the award, fix the amount of any fee allowed to any person for services in connection with presenting the claim, and it shall be a misdemeanor punishable by a fine of not more than five hundred dollars, or imprisonment for not more than six months, or both, to accept any remuneration for the services other than that provided by the referee or board.

Sec 311 Unless the employe or someone in his behalf, or some of the dependents or someone in their behalf, shall give notice of disability to the employer liable for compensation under this article, within twenty-one days after compensation disability begins, no compensation shall be due until such notice be given, and unless such notice be given within one hundred and twenty days after the beginning of compensable disability no compensation shall be allowed.

Sec 312 The notice referred to in section three hundred and eleven shall inform the employer that a certain employe became disabled as a result of the occupational disease, described in ordinary language, in the course of his employment on or about a specified time.

Sec 313 The notice referred to in sections three hundred and eleven and three hundred and twelve may be given to the immediate or other superior of the employe, to the employer, or any agent of the employer regularly employed at the place of employment of the disabled employe.

Sec 314 At any time after disability begins, the employe must submit himself for examination, at some reasonable time and place, to a physician or physicians legally authorized to practice under the laws of such place, who shall be selected and paid for by the employer, or the Commonwealth, and the report of the examination of the physician, with his testimony, shall be made a part of the record before a claim for disability shall be allowed by the referee of the Board: Provided, That in the case where there has been an examination by a physician selected and paid for by the Commonwealth, there shall be, in addition an examination by an independent physician selected and paid for by the employer, who shall file a report and testify and who shall not be allowed under any circumstances to adopt the report or the testimony or the examination of the physician of any other party. If the employe shall refuse to submit to the examination by the physician or physicians selected by the employer or the Commonwealth, the board shall order the employe to submit to an examination at a time and place set by it and by the physician or physicians selected and paid by the employer or the Commonwealth, or by a physician or physicians designated by it and paid by the employer or the Commonwealth. The board may at any time after such first examination order the employe to submit himself to such further examinations as it shall deem reasonable and necessary, at such times and places and by such physicians as it may designate; and, in such case, the employer or the Commonwealth shall pay the fees and expenses of the examining physician or physicians, and the reasonable traveling expenses and loss of wages incurred by the employe in order to submit himself to such examination. The refusal or neglect, without reasonable cause or excuse,

of the employe to submit to such examination ordered by the board, either before or after an agreement or award, shall deprive him of the right to compensation under this article, during the continuance of such refusal or neglect, and the period of such neglect or refusal shall be deducted from the period during which compensation would otherwise be payable.

The employe shall be entitled to have a physician or physicians of his own selection, to be paid by him, participate in any examination ordered by the board.

Sec 315 In cases of disability all claims for compensation shall be forever barred, unless, within sixteen months after compensable disability begins, the parties shall have agreed upon the compensation payable under this article, or unless, within sixteen months after compensable disability begins, one of the parties shall have filed a petition as provided in article four hereof. Where, however, a person is receiving benefits pursuant to the act of June 28, 1935 (P.L. 477, No. 193), referred to as the Heart and Lung Act, the sixteen-month period in which parties must agree on compensation payable or file a petition for compensation in cases of personal injury or cases of death, shall not begin to run until the expiration of the receipt of benefits pursuant to the Heart and Lung Act. In cases of death all claims for compensation shall be forever barred, unless, within sixteen months after the death, the parties shall have agreed upon the compensation payable under this article, or unless, within sixteen months after the death, one of the parties shall have filed a petition as provided in article four hereof. Where, however, payments of compensation have been made in any case, said limitations shall not take effect until the expiration of sixteen months from the time of the making of the most recent payment made prior to the date of filing such petition.

In cases of total disability from silicosis, anthracosilicosis, coal worker's pneumoconiosis, and asbestosis where the claim is allowed, compensation shall be payable and commence as of the date the claim is filed.

Sec 316 The compensation contemplated by this article may at any time be commuted by the board, at its then value when discounted at five per centum interest, with annual rests, upon application of either party, with due notice to the other, if it appears that such commutation will be for the best interest of the employe or the dependents of the deceased employe, and that it will avoid undue expense or undue hardship to either party, or that such employe or dependent has removed or is about to remove from the United States, or that the employer has sold or otherwise disposed of the whole or the greater part of his business or assets: Provided, however, That unless the employer agrees to make such commutation, the board may require the employe or the dependents of the deceased employe to furnish proper indemnity safeguarding the employer's rights.

Sec 317 At any time after the approval of an agreement or after the entry of the award, a sum equal to all further installments of compensation may (where death or the nature of the disability renders the amount of future payments certain), with the approval of the board, be paid by the employer to any savings bank, trust company, or life insurance company, in good standing and authorized to do business in this Commonwealth, and such sum, together with all interest thereon, shall thereafter be held in trust for the employe or the dependents of the employe, who shall have no further recourse against the employer. The payment of such sum by the employer, evidenced by the receipt of the trustee noted upon the prothonotary's docket, shall operate as a satisfaction of said award as to the employer. Payments from said fund shall be made by the trustee in the same amounts and at the same periods as are herein required by the employer, until said fund and interest shall be exhausted. In the appointment of the trustee preference shall be given, in the discretion of the board, to the choice of the employe or the dependents of the deceased employe. Should, however, there remain any unexpended balance of any fund after the payment of all sums due under this act, such balance shall be repaid to the employer who made the original payment, or to his legal representatives.

Sec 318 The right of compensation granted by this article shall have the same preference (without limit of amount) against the assets of an employer, liable for such compensation, as is now or may hereafter be allowed by law for a claim for unpaid wages for labor: Provided, however, That no claim for compensation shall have priority over any judgment, mortgage, or conveyance of land recorded prior to the filing of the

petition, award, or agreement as to compensation in the office of the prothonotary of the county in which the land is situated. Claims for payments due under this article of this act and compensation payments made by virtue thereof shall not be assignable, and (except as provided in section three hundred and nineteen of article three and section five hundred and one of article five hereof) shall be exempt from all claims of creditors, and from levy, execution, or attachment, which exemption may not be waived.

Sec 319 Where the compensable disability is caused in whole or in part by the act or omission of a third party, the employer shall be subrogated to the right of the employe, his personal representative, his estate or his dependents, against such third party for the balance of any sum recovered in litigation, or paid in compromise settlement, after subtraction of reasonable attorney's fees and other proper disbursements, but only to the extent of the compensation payable under this article by the employer. Any recovery against such third person in excess of the compensation theretofore paid by the employer shall be paid forthwith to the employe or to the dependents, and shall be treated as an advance payment by the employer on account of any future installments of compensation.

Where an employe has received payments for the disability or medical expense resulting from a disability in the course of his employment, paid by the employer or an insurance company on the basis that the disability was not compensable under this act, in the event of an agreement or award for that disability, the employer or insurance company, who made the payments, shall be subrogated out of the agreement or award to the amount so paid, if the right to subrogation is agreed to by the parties or is established at the time of hearing before the referee or the board.

- Sec 320
- (a) If the employe is a minor, under the age of eighteen years, employed or permitted to work in violation of any provision of the laws of this Commonwealth relating to minors of such age, compensation, either in the case of disability or death of such employe, shall be one hundred and fifty per centum of the amount that would be payable to such minor if legally employed. The amount by which such compensation shall exceed that provided for in case of legal employment may be referred to as "additional compensation."
 - (b) The employer and not the insurance carrier shall be liable for the additional compensation. Any provision in an insurance policy undertaking to relieve an employer from such liability shall be void.
 - (c) Where death or the nature of the disability renders the amount of future payments certain, the total amount of the additional compensation, subject to discount as in the case of commutation, shall be immediately due and payable. It shall be deposited, subject to the approval of the board, in any savings bank, trust company, or life insurance company in good standing and authorized to do business in this Commonwealth.

Where the amount of the future payments of compensation is uncertain, the board shall, upon the approval of the agreement or the entry of an award, determine as nearly as may be the total amount of payment to be made, and the additional compensation so calculated shall, immediately upon such determination, become due and payable by the employer. The amount may be redetermined by the board, and any increase shall then become due and payable, and any excess, which shall be shown to have been paid, shall be returned to the person paying the same. Upon determination of the amount due, it shall be deposited as above provided. Payments of compensation out of deposits shall be made to the employe or dependents as payments of other compensation are made: Provided, however, That the board may, in its discretion and upon inquiry as in cases of commutation, accelerate such payments.

- (d) The provisions of the foregoing paragraph (c) shall not apply to employers who are exempted by the department from the necessity of carrying insurance.
- (e) Possession of an employment certificate, duly issued and transmitted to the employer in accordance with the provisions of the child labor law, and receipt thereof duly acknowledged by him,

shall be conclusive evidence to such employer of his legal right to employ the minor for whose employment such certificate has been issued.

- (f) The possession of an age certificate, duly issued and transmitted to the employer by the school authorities of the school district in which a minor resides, shall be conclusive evidence to the employer of the minor's age as certified therein.
- (g) If neither party has elected not to be bound by the provisions of article three of the act to which this act is an amendment, in the manner prescribed by section three hundred and two of said act, they shall be held to have agreed to be bound by the provisions of this act, and to have waived any other right or remedy at law or in equity, for the recovery of damages for injuries occurring under the circumstances herein described.

ARTICLE IV
Procedure

Sec 401 The term “employer,” when used in this article, shall mean the employer as defined in article one of this act, or his duly authorized agent, or his insurer if such insurer has assumed the employer’s liability, or the State Workmen’s Insurance Fund of this Commonwealth if the employer be insured therein.

The department shall be deemed a “party in interest” in any proceeding under this article before a referee, the board or any court involving any claim for compensation, a part of which is payable by the Commonwealth under the provisions of this act.

Sec 402 Repealed.

Sec 403 (a) All proceedings before the board or any referee, and all appeals to the board, shall be instituted by petition addressed to the board. All petitions shall be in writing and in the form prescribed by the board.

(b) All petitions, all copies of agreements for compensation, and all papers requiring action by the board, shall be mailed or delivered to the department at its principal office.

Sec 404 The department shall, immediately upon their receipt, properly file and docket all petitions, agreements for compensation, findings of fact by the board or any referee, awards or disallowances of compensation, or modifications thereof, and all other reports or papers filed with it under the provisions of this act or the rules or regulations of the board.

Sec 405 Immediately upon receiving from the board or any referee any award or disallowance of compensation, or any modification thereof, or any other decision, the department shall serve a copy thereof on all parties in interest.

Sec 406 All notices and copies to which any party shall be entitled under the provisions of this article shall be served by mail, or in such manner as the board shall direct. For the purposes of this article any notice or copy shall be deemed served on the date when mailed, properly stamped and addressed, and shall be presumed to have reached the party to be served; but any party may show by competent evidence that any notice or copy was not received, or that there was an unusual or unreasonable delay in its transmission through the mails. In any such case proper allowance shall be made for the party’s failure within the prescribed time to assert any right given him by this act.

The department, the secretary of the board, and every referee shall keep a careful record of the date of mailing every notice and copy required by this act to be served on the parties in interest.

Sec 407 On or after the seventh day after disability shall have begun or death shall have occurred, the employer and employe or his dependents may agree upon the compensation payable to the employe or his dependents under this act; but any agreement made prior to the seventh day after the disability shall have begun or the death shall have occurred, or permitting a commutation of payments contrary to the provisions of this act, or varying the amount to be paid or the period during which compensation shall be payable as provided in this act, shall be wholly null and void. It shall be unlawful for any employer to accept a receipt showing the payment of compensation when in fact no such payment has been made.

All agreements made in accordance with the provisions of this section shall be in writing, and signed by all parties in interest.

All agreements for compensation and all supplemental agreements for the modification, suspension, reinstatement, or termination thereof, and all receipts executed by any employe of whatever age, or by any dependent to whom compensation is payable under section three hundred and seven, and who has attained the age of sixteen years, shall be valid and binding unless modified or set aside as hereinafter

- provided.
- Sec 408 All agreements for compensation may be modified, suspended, reinstated, or terminated at any time by a supplemental agreement approved by the department, if the disability of an employe has increased, decreased, recurred, or temporarily or finally terminated, or if the status of any dependent has changed.
- Sec 409 Whenever an agreement or supplemental agreement shall be executed between an employer and employe or his dependents as provided by this act, such agreement shall be executed in triplicate. Two copies thereof, signed by all parties in interest, shall be mailed or delivered to the department within thirty days after execution. It shall be the duty of the department to examine the agreement to determine whether it conforms to the provisions of section four hundred and seven, to notify the parties thereto of its validity or invalidity, under the aforesaid section, within thirty days after the copies of the agreement have been mailed or delivered to it, and, if the agreement be approved, to send to the employe or dependents, together with such notification of its approval, a copy of the agreement: Provided, however, That any payment made in accordance with any agreement prior to the receipt of notice of invalidity shall discharge pro tanto the liability, under article three of this act, of the employer making such payments.
- Sec 410 If, after any disability or death, the employer and the employe or his dependents shall fail to agree upon the facts thereof and the compensation due under this act, the employe or his dependents may present a claim for compensation to the board.
- Whenever any claim for compensation is presented to the board, and is finally adjudicated in favor of the claimant, the amounts of compensation actually due at the time the first payment is made after such adjudication shall bear interest at the rate of six per centum per annum from the day such claim is presented, and such interest shall be payable to the same persons to whom the compensation is payable.
- In case any claimant shall die before the final adjudication of his claim, the amount of compensation due such claimant to the date of death shall be paid to the dependents entitled to compensation, or, if there be no dependents, then to the estate of the decedent.
- Sec 411 Whenever the employer and the employe or his dependent shall, on or after the seventh day after any disability begins or death occurs, agree on the facts on which a claim for compensation depends, but shall fail to agree on the compensation payable thereunder, they may petition the board to determine the compensation payable. Such petition shall contain the agreed facts, and shall be signed by all parties in interest. The board shall fix a time and place for hearing the petition, and shall notify all parties in interest. As soon as may be after such hearing, the board shall award or disallow compensation in accordance with the provisions of this act.
- Sec 412 If any party shall desire the commutation of future installments of compensation, he shall present a petition therefor to the board.
- Sec 413 The board, or a referee designated by the board, may, at any time, review and modify or set aside an existing original or existing supplemental agreement, upon petition filed by either party with the board or in the course of the proceedings under any petition pending before such board or referee, if it be proved that such agreement was in any material respect incorrect.
- The board, or a referee designated by the board, may, at any time, modify, reinstate, suspend, or terminate an original or supplemental agreement or an award, upon petition filed by either party with such board, upon proof that the disability of the employe has increased, decreased, recurred, or has temporarily or finally ceased, or that the status of any dependent has changed. Such modification, reinstatement, suspension, or termination shall be made as of the date upon which it is shown that the disability of the employe has increased, decreased, recurred, or has temporarily or finally ceased, or upon which it is shown that the status of any dependent has changed: Provided, That an agreement or award can only be reviewed, or modified, or reinstated, during the time such agreement or award has to run, if for a definite period; and no agreement or award shall be reviewed, or modified, or reinstated, unless a

petition is filed with the board within two years after the date of the most recent payment of compensation made prior to the date of filing such petition. Where, however, a person is receiving benefits pursuant to the act of June 28, 1935 (P.L. 477, No. 193), referred to as the Heart and Lung Act, the two-year period in which a petition to review, modify, or reinstate a notice of compensation, agreement or award must be filed, shall not begin to run until the expiration of the receipt of benefits pursuant to said Heart and Lung Act. Where compensation has been suspended because the employe's earnings are equal to or in excess of his wages prior to the disability payments under the agreement or award may be resumed at any time during the period for which compensation for partial disability is payable, unless it be shown that the loss of earnings does not result from the disability due to the exposure.

The board or referee to whom any such petition has been assigned may subpoena witnesses, hear evidence, make findings of fact, and award, or disallow compensation in the same manner and with the same effect and subject to the same right of appeal, as if such petition were an original claim petition.

The filing of a petition to terminate or modify a compensation agreement or award as provided in this section shall operate as a supersedeas, and shall suspend the payment of compensation fixed in the agreement or by the award, in whole or to such extent as the facts alleged in the petition would if proved, require.

Sec 414 Whenever a claim petition or other petition is presented to the board, the board shall, by general rules or special order, either direct it to be heard by one or more members of the board or assign it to a referee for hearing: Provided, however, That petitions presented under sections four hundred and eleven and four hundred and twelve shall be heard by one or more members of the board.

The department shall serve upon each adverse party a copy of the petition, together with a notice that such petition will be heard by the board or the referee to whom it has been assigned (giving his name and address), as the case may be, and, if the petition shall have been assigned to a referee, shall mail the original petition to such referee, together with copies of the notices served upon the adverse parties.

Sec 415 At any time before an award or disallowance of compensation or order has been made by a referee to whom a petition has been assigned, the board may order such petition heard before it or one or more of its members or may reassign it to any other referee. Unless the board shall otherwise order, the testimony taken before the original referee shall be considered as though taken before the board or substituted referee.

Sec 416 Within twenty days after a copy of any petition has been served upon any adverse party, he may file with the secretary of the board if the petition has been directed to be heard by the board, or with the referee if the petition has been assigned to a referee, an answer in the form prescribed by the board.

Every fact alleged in a claim petition not specifically denied by an answer so filed by an adverse party shall be deemed to be admitted by him. But the failure of any adverse party, or of all of them, to deny a fact so alleged shall not preclude the board or referee before whom the petition is heard from requiring, of its or his own motion, proof of such fact.

Sec 417 As soon as may be after the twelfth day after notice that a petition has been directed to be heard by the board has been served upon the adverse parties thereto, the board shall fix a time and place for hearing the petition. If a petition be assigned to a referee, he shall, as soon as practicable thereafter, fix a time and a place for hearing the petition. The secretary of the board, if the petition has been directed to be heard by the board or by one or more of its members, or the referee to whom the petition has been assigned, shall serve upon all parties in interest a notice of the time and place of hearing, and shall serve upon the petitioner a copy of any answer of any adverse party.

Sec 418 The board, if a petition is directed to be heard by it or by one or more of its members, or the referee to whom a petition is assigned for hearing may subpoena witnesses, order the production of books and other writings, and hear evidence, and shall make, in writing and as soon as may be after the conclusion of the hearing, such findings of fact, conclusions of law, and award or disallowance of compensation, or

other order, as the petition and answers and the evidence produced before it or him and the provisions of this act shall, in its or his judgment, require. The findings of fact made by the board in any petition heard by it or by one or more of its members or upon a hearing de novo shall be final, except as hereinafter provided, and the findings of fact made by a referee to whom a petition has been assigned or any question of fact has been referred under the provisions of section four hundred and nineteen shall be final, unless an appeal is taken as provided in this act, or unless the board shall, under the provisions of sections four hundred and twenty-five or four hundred and twenty-six of this article, grant a hearing de novo or a rehearing.

Sec 419 The board may refer any question of fact arising under any petition, including a petition for commutation heard by it, to a referee to hear evidence and report to the board the testimony taken before him or such testimony and findings of facts thereon as the board may order. The board may refer any question of fact arising out of any petition assigned to a referee, to any other referee to hear evidence and report the testimony so taken thereon to the original referee.

Sec 420 The board or a referee, if it or he deem it necessary, may, of its or his own motion, either before, during, or after any hearing, make an investigation of the facts set forth in the petition or answer. The board or referee with the consent of the board, may appoint one or more impartial physicians or surgeons to examine the claimant and report thereon, or he may employ the services of such other experts as shall appear necessary to ascertain the facts. The report of any physician, surgeon, or expert appointed by the board or by a referee, shall be filed with the board or referee, as the case may be, and shall be a part of the record and open to inspection as such.

The board shall fix the compensation of such physicians, surgeons, and experts, which, when so fixed, shall be paid out of the sum appropriated to the Department of Labor and Industry.

The sum of fifty thousand dollars (\$50,000) is hereby appropriated to the Department of Labor and Industry for compensation payable by the Commonwealth under the provisions of this section for the biennium one thousand nine hundred fifty-five — one thousand nine hundred fifty-seven.

Sec 421 All hearings before the board or one or more members thereof, or before a referee, shall be public.

Sec 422 The board, its members and the referees shall not be bound by the technical rules of evidence in conducting hearings and investigations, but all findings of fact shall be based only upon sufficient, competent evidence to justify them.

If any party or witness resides outside of the Commonwealth, or through illness or other cause is unable to testify before the board or a referee, his or her testimony or deposition may be taken, within or without this Commonwealth, in such manner and in such form as the board may, by special order or general rule, prescribe. The records, kept by a hospital of the medical or surgical treatment given to an employe in such hospital, shall be admissible as evidence of the medical and surgical matters stated therein, but shall not be conclusive proof of such matters.

Where any claim for compensation at issue before a referee involves five weeks or less of disability, either the employe or the employer may submit a certificate by any qualified physician as to the history, examination, treatment, diagnosis and cause of the condition, and the statements shall be admissible as evidence of medical and surgical matters therein stated, but such statements and certificates shall not be admissible in any subsequent proceedings.

Where an employer has furnished surgical and medical services or hospitalization in accordance with the provisions of subsection (f) of section 306, or where the employe has himself procured them, the employer or employe shall, upon request, in any pending proceeding be furnished with or have made available a true and complete record of the medical and surgical services and hospital treatment, including X-rays, laboratory tests, and all other medical and surgical data in the possession or under the control of the party requested to furnish or make available such data.

Sec 423 Any party in interest may, within twenty days after notice of a referee's award or disallowance of compensation shall have been served upon him, take an appeal to the board on the ground: (1) that the award or disallowance of compensation is not in conformity with the terms of this act, or that the referee committed any other error of law; (2) that the findings of fact and award or disallowance of compensation was unwarranted by sufficient, competent evidence, or was procured by fraud, coercion, or other improper conduct of any party in interest. The board may, upon cause shown, extend the time provided in this article for taking such appeal or for the filing of an answer or other pleading.

In any such appeal the board may disregard the findings of fact of the referee, and may examine the testimony taken before such referee, and if it deem proper may hear other evidence, and may substitute for the finds of the referee such findings of fact as the evidence taken before the referee and the board, as hereinbefore provided, may, in the judgment of the board, require, and may make such disallowance or award of compensation or other order as the facts so founded by it may require.

Sec 424 Whenever an appeal shall be based upon an alleged error of law, it shall be the duty of the board to grant a hearing thereon. The board shall fix a time and place for such hearing, and shall serve notice thereof on all parties in interest.

As soon as may be after such hearing, the board shall either sustain or reverse the referee's award or disallowance of compensation, or make such modification thereof as it shall deem proper.

Sec 425 Whenever an appeal shall be taken on the ground that the referee's award or disallowance of compensation was unwarranted by the evidence, or because of fraud, coercion, or other improper conduct by any party in interest, the board may, in its discretion, grant a hearing de novo before the board or one or more of its members, or assign the petition for rehearing to any referee designated by it, or sustain the referee's award or disallowance of compensation. If the board shall grant a hearing de novo, it shall fix a time and place therefor and notify all parties in interest.

As soon as may be after any hearing de novo by the board, it shall in writing state its findings of fact, and award or disallow compensation in accordance with the provisions of this act.

Sec 426 The board, upon petition of any party and upon cause shown, at any time before the court of common pleas of any county of this Commonwealth, to which an appeal has been taken under the provisions of section four hundred and twenty-seven of this article shall have taken final action thereon, may grant a rehearing of any petition upon which the board has made an award or disallowance of compensation or other order or ruling, or upon which the board has sustained or reversed any action of referee; but such rehearing shall not be granted more than eighteen months after the board has made such award, disallowance, or order or ruling, or has sustained or reversed any action of the referee. If the board shall grant a rehearing of any petition from the board's action on which an appeal has been taken to and is pending in the court of common pleas under the provisions of section four hundred and twenty-seven of this article, the board shall file in such court a certified copy of its order granting such rehearing, and it shall thereupon be the duty of such court to cause the record of the case to be remitted to the board: Provided, however, That nothing contained in this section shall limit or restrict the right of the board, or a referee designated by the board, to review, modify, set aside, reinstate, suspend, or terminate, an original or supplemental agreement, or an award in accordance with the provisions of section four hundred thirteen of this article.

Sec 427 Any party may appeal from any action of the board on matters of law to the court of common pleas of the county in which the employe was last employed prior to his disability or death or of the county in which the adverse party resides or has a permanent place of business, or, by agreement of the parties, to the court of common pleas of any other county of this Commonwealth. The party taking the appeal shall, at the time of taking the appeal, serve upon the adverse party a written notice thereof, setting forth the date of the appeal and the court in which the same is filed, and shall file, either with his notice of appeal, or within thirty days thereafter, such exceptions to the action of the board as he may desire to

take, and shall specify the findings of fact, if any, of the board, or of the referee sustained by the board, which he alleges to be unsupported by sufficient, competent evidence.

Upon filing of the notice of an appeal, the prothonotary of the court of common pleas to which the appeal has been taken shall issue a writ of certiorari, directed to the board, commanding it, within ten days after service thereof, to certify to such court its entire record in the matter in which the appeal has been taken. The writ so issued shall be mailed by the prothonotary to the department at Harrisburg, together with a copy of the exceptions. The board shall, within ten days after such service, certify to such court its entire record in the matter in which the appeal has been taken, including the notes of testimony.

Any court before which an appeal is pending from any action of the board, may remit the record to the board for more specific findings of fact if the findings of the board or referee or of the medical board are not, in its opinion, sufficient to enable it to decide the question of law raised by the appeal.

If the court of common pleas shall affirm an award or order of the board or of a referee, sustained by the board, fixing the compensation payable under this act, the court shall enter judgment for the total amount stated by the award or order to be payable, whether then due and accrued or payable in future installments. If such court shall sustain the appellant's exceptions to a finding or findings of fact and reverse the action of the board founded thereon, the court shall remit the record to the board for further hearing and determination, in which the procedure shall be the same as that hereinbefore provided in this article in the case of petition presented to the board, except that the testimony taken in the original proceedings shall be considered as though taken in such further hearing.

The prothonotary of any court of common pleas to which an appeal has been taken from the board, shall send to the board a certificate of the judgment of the court as soon as rendered, with a copy of any opinion which may be filed in the case, and, within five days, shall give notice of such judgment, and the date thereof, by registered mail to each attorney at law appearing in the case at the address given by the attorney in the pleadings, and, if no attorney at law has appeared by registered mail to the party or parties not represented by counsel. At the end of the period allowed for an appeal from the judgment of the court, the record of the board shall be remitted to it by the prothonotary unless an appeal shall have been taken. If such appeal shall be taken, the record shall be remitted to the board by the prothonotary on its return from the appellate court.

Sec 428

Whenever the employer, who has accepted and complied with the provisions of section three hundred five, shall be in default in compensation payments for thirty days or more, the employe or dependents entitled to compensation thereunder may file a certified copy of the agreement and the order of the board approving the same, or of the award or order, with the prothonotary of the court of common pleas of any county, and the prothonotary shall enter the entire balance payable under the agreement, award or order to be payable to the employe or his dependents, as a judgment against the employer or other party liable under such agreement or award. Where the compensation so payable is for a total and permanent disability, the judgment shall be in the amount of thirty thousand dollars less such amount as the employer shall have actually paid pursuant to such agreement or award. Such judgment shall be a lien against property of the employer or other party liable under such agreement or award, and execution may issue thereon forthwith.

Wherever, after disability or death, any employe or his dependents shall have entered into a compensation agreement with an employer liable for compensation under this act, who has not accepted or complied with the provisions of section three hundred five, or shall file a claim petition against such employer, he may file a certified copy thereof with the prothonotary of the court of common pleas of any county. The prothonotary shall enter the amount stipulated in any such agreement or claimed in any such petition as judgment against the employer, and where the amount so stipulated or claimed is for total disability, such judgment shall be in the sum of thirty thousand dollars. If the agreement be approved by the department, or compensation awarded as claimed in the petition, the amount of compensation stipulated in the agreement or claimed in the petition shall be a lien, as of the date when the agreement or petition was filed with the prothonotary. Pending the approval of the agreement or the award of compensation,

no other lien which may be attached to the employer's property during such time shall gain priority over the lien of such agreement or award, but no execution shall issue on any compensation judgment before the approval of the agreement or the award of compensation on the said petition.

If the agreement be disapproved, or, after hearing, compensation shall be disallowed, the employer may file, with the prothonotary of any county in which the petition or agreement is on record as a judgment, a certified copy of the disapproval of the agreement or disallowance of compensation, and it shall be the duty of such prothonotary to strike off the judgment.

If the amount of compensation claimed be disallowed, but another amount awarded, the compensation judgment shall be a lien to the extent of the award, as of the date of filing the petition with the prothonotary, with the same effect as to other liens and the same disability to issue execution thereon as if the compensation claimed had been allowed. In such cases the prothonotary shall make such modification of the record as shall be appropriate.

If the compensation payable under any agreement or award upon which judgment has been entered under the provisions of this section shall be modified, suspended, reinstated, or terminated by a supplemental agreement executed under the provisions of section four hundred and eight, or by an award or order made under the provisions of section four hundred and thirteen, any party to such judgment, at any time after such agreement has been approved by the department or after the expiration of the time allowed for an appeal from the award or order, may file with the prothonotary of the court of common pleas of any county in which the judgment is on record a certified copy of such supplemental agreement, award, or order, and it shall thereupon be the duty of the prothonotary to modify, suspend, reinstate, or satisfy such judgment in accordance with the terms of such supplemental agreement, award or order.

Execution may issue by first filing with the prothonotary an affidavit that there has been a default in payments of compensation due on any judgment for compensation, entered prior to the approval of the compensation agreement, or an award on petition, as soon as such agreement shall have been approved by the department, or such award made as evidenced by the approval of the board of the award or by a certified copy thereof.

Execution shall in all cases be for the amount of compensation and interest thereon due and payable up to the date of the issuance of said execution, with costs, and further execution may issue from time to time as further compensation shall become due and payable, until full amount of the judgment with costs shall have actually been paid.

Sec 429

If any party against whom a compensation agreement, award, or other order fixing the compensation payable under this act has been filed of record in any county of this Commonwealth in accordance with the provisions of section four hundred and twenty-eight of this article, or against whom judgment has been entered by the prothonotary of the court of common pleas of any county on any award or order of the board or a referee, shall, at any time, present to the board receipts or copies thereof, certified by any referee, showing the payment of compensation as required by the agreement or award in full to the date of presentation to the referee, the board shall issue a certificate to such party, in the form prescribed, stating the extent to which the judgment on the agreement or award has been reduced. Upon the presentation of such certificate to the prothonotary of the court of common pleas of any county in which such agreement or award has been filed of record as a judgment, or in which judgment on an award has been entered by the prothonotary of the court of common pleas, it shall be the prothonotary's duty to mark such judgment satisfied to the extent of the payments so certified, and, upon the presentation to such prothonotary of a certificate issued by the board under the provisions of section three hundred and seventeen of this act, it shall be the duty of the prothonotary to mark such judgment fully satisfied.

Sec 430

The lien of any judgment entered upon any award shall not be divested by any appeal. If, however, the party appealing from the award shall file with the board a bond, in such amount and in such form as the rules and regulations of the board shall direct, the appeal shall, pending its decision, excuse the payment of so much of the compensation as is contested therein; but if the final decision on appeal shall sustain

the award, it shall be the duty of the employer by whom such award is payable to make payments of compensation as from the date of the original award. If on appeal the award is sustained as to a part, it shall be the duty of the employer by whom such part is payable to make payments as from the date of the original award. In case the award is annulled on appeal, it shall be the duty of the prothonotary of any county in which such award has been entered as a judgment to make it satisfied.

Sec 431 The cost of the prothonotary for entering the amount of compensation as provided in this act, or making a modification of the record, or marking the judgment satisfied, shall be allowed, taxed, and collected as upon a confession of judgment on a judgment note.

Sec 432 Repealed.

Sec 433 Repealed.

Sec 434 A final receipt, given by an employe or dependent entitled to compensation under a compensation agreement or award, shall be prima facie evidence of the termination of the employer's liability to pay compensation under such agreement or award: Provided, however, That the board, or a referee designated by the board, may, at any time within two years from the date to which payments have been made, set aside a final receipt, upon petition filed with the board, if it be conclusively proved that all disability due to the occupational disease in fact had not terminated. Where, however, a person is receiving benefits pursuant to the act of June 28, 1935 (P.L. 477, No. 193), referred to as the Heart and Lung Act, the two-year period within which the board or a referee designated by the board may set aside a final receipt upon petition filed with the board, shall not begin to run until the expiration of receipt of benefits under the Heart and Lung Act.

ARTICLE V
General Provisions

Sec 501 No claim or agreement for legal services or disbursements in support of any demand made or suit brought under the provisions of article two of this act shall be an enforceable lien against the amount to be paid as damages, or be valid or binding in any respect, unless the same be approved in writing by the judge presiding at the trial, or, in case of settlement without trial, by a judge of the common pleas court of the county in which the accident occurred.

No claim or agreement for legal services or disbursements in support of any claim for compensation, or in preparing any agreement for compensation, under article three of this act, shall be an enforceable lien against the amount to be paid as compensation, or be valid or binding in any other respect, unless the same be approved by the board. Any such claim or agreement shall be filed with the department, which shall, as soon as may be, notify the person by whom the same was filed of the board's approval or disapproval thereof, as the case may be.

After the approval as herein required, if the employer be notified in writing of such claim or agreement for legal services and disbursements, the same shall be a lien against any amount thereafter to be paid as damages or compensation: Provided, however, That where the employe's compensation is payable by the employer in periodical installments, the board shall fix, at the time of approval, the proportion of each installment to be paid on account of legal services and disbursements, and the board may, upon application made to it, commute the sum awarded for legal services and disbursements.

Sec 501.1 Any person who solicits money for assisting any person to obtain any benefits under this act shall be guilty of a misdemeanor and upon conviction thereof shall be sentenced to pay a fine not to exceed one thousand dollars (\$1,000) and costs of prosecution, or to undergo imprisonment for one year, or both. This provision shall not apply to an attorney at law who for a fee has been retained by a claimant to give him legal advice and assistance in obtaining benefits.

Sec 502 Nothing in this act shall affect or impair any rights of action which have accrued before this act shall take effect.

Sec 503 If any provision of this act shall be held by any court to be unconstitutional, such judgment shall not affect any other section or provision of this act, except that articles two and three are hereby declared to be inseparable and as one legislative thought, and if either article be declared by such court void or inoperative in an essential part so that the whole of such article must fall, the other article shall fall with it and not stand alone.

Sec 504 The following acts are hereby specifically repealed: The act, approved the second day of July, one thousand, nine hundred thirty-seven (Pamphlet Laws, twenty seven hundred fourteen), entitled "A supplement to the act, approved the second day of June, one thousand nine hundred fifteen (Pamphlet Laws, seven hundred thirty-six), entitled, as amended 'An act defining the liability of an employer to pay damages for injuries received by an employe in the course of employment; establishing a system and schedule of compensation; providing procedure for the determination of liability and compensation thereunder; and prescribing penalties,' as amended and reenacted, providing for the inclusion of occupational diseases within the scope thereof, and providing definitions, provisions, and procedure related to such disease; and making an appropriation."

All other acts and parts of act inconsistent with the provisions of this act.

Sec 505 The provisions of this act shall become effective on October first, one thousand nine hundred and thirty-nine, except the provisions of section three hundred two of this act, which shall become effective immediately upon the final enactment of this act.

[Editor's Note: Regulations promulgated for Act 57 of 1996.]

TITLE 34. LABOR AND INDUSTRY
PART VIII. BUREAU OF WORKERS' COMPENSATION
CHAPTER 123. GENERAL PROVISIONS PART II

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

§ 123.1. Purpose.

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

§ 123.2. Definitions.

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

ADR — Alternative Dispute Resolution.

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

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

CBA — Collective Bargaining Agreements.

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

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

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

IRE — Impairment Rating Evaluation.

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

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

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

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

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

§ 123.3. **Employe report of benefits subject to offset.**

- (a) Employes shall report to the insurer amounts received in unemployment compensation, Social Security (old age), severance and pension benefits on form LIBC-756, "Employee's Report of Benefits." This includes amounts withdrawn or otherwise utilized from pension benefits which are rolled over into an IRA or other similarly restricted account while at the same time the employe is receiving workers' compensation benefits.
- (b) Form LIBC-756 shall be completed and forwarded to the insurer within 30 days of the employe's receipt of any of the benefits specified in subsection (a) or within 30 days of any change in the receipt of the benefits specified in subsection (a), but at least every 6 months.

§ 123.4. **Application of the offset generally.**

- (a) After receipt of Form LIBC-756, the insurer may offset workers' compensation benefits by amounts received by the employe from any of the sources in § 123.3 (relating to employe report of benefits subject to offset). The offset of workers' compensation benefits only applies with respect to amounts of unemployment compensation, Social Security (old age), severance and pension benefits received subsequent to the work-related injury.
 - (1) The offset applies only to wage-loss benefits (as opposed to medical benefits, specific loss or survivor benefits).
 - (2) The offset for amounts received in Social Security (old age), severance and pension benefits only applies to individuals with claims for injuries suffered on or after June 24, 1996.
 - (3) The offset for amounts received in unemployment compensation benefits applies to all claims regardless of the date of injury.
- (b) At least 20 days prior to taking the offset, the insurer shall notify the employe, on Form LIBC-761, "Notice of Workers' Compensation Benefit Offset," that the workers' compensation benefits will be offset. The notice shall indicate:
 - (1) The amount of the offset.
 - (2) The type of offset (that is - unemployment compensation, Social Security (old age), severance or pension).
 - (3) How the offset was calculated, with supporting documentation, which may include information provided by the employe.
 - (4) When the offset commences.

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- (5) The amount of any recoupment, if applicable.
 - (c) Whenever the insurer's entitlement to the offset changes, the insurer shall notify the employe of the change at least 20 days prior to the adjustment on Form LIBC-761.
 - (d) The insurer shall provide a copy of Form LIBC-761, to the employe, the employe's counsel, if known, and the Department. The form shall be provided to the employe consistent with section 406 of the act (77 P. S. § 717).
 - (e) The employe may challenge the offset by filing a petition to review offset with the Department.
 - (f) When Federal, State or local taxes are paid with respect to amounts an employe receives in unemployment compensation, Social Security (old age), severance or pension benefits, the insurer shall repay the employe for amounts previously offset, and paid in taxes, from workers' compensation benefits, when the offset was calculated on the pretax amount of the benefit received. To request repayment for amounts previously offset and paid in taxes, the employe shall notify the insurer in writing of the amounts paid in taxes previously included in the offset.

§ 123.5. Offset for benefits already received.

- (a) If the insurer receives information that the employe has received benefits from one or more of the sources in § 123.3 (relating to employe report of benefits subject to offset) subsequent to the date of injury, the insurer may be entitled to an offset to the workers' compensation benefit.
- (b) The net amount received by the employe shall be calculated consistent with §§ 123.6 - 123.11. The amount received by the employe shall be divided by the weekly workers' compensation rate. The result shall be the number of weeks, and fraction thereof, the insurer is entitled to offset against future payments of workers' compensation benefits.
- (c) The insurer shall notify the employe, the employe's counsel, if known, and the Department of the offset as specified in § 123.4(b) (relating to application of the offset generally).
- (d) The employe may challenge the offset by filing a petition to review offset with the Department.

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

- (a) Workers' compensation benefits otherwise payable shall be offset by the net amount an employe receives in UC benefits subsequent to the work-related injury. This offset applies only to UC benefits which an employe receives and which are attributable to the same time period in which an employe also receives workers' compensation benefits.
- (b) The offset may not apply to benefits for which an employe may be eligible, but is not receiving.
- (c) The offset to workers' compensation benefits for amounts received in UC benefits is triggered when an employe becomes eligible for and begins receiving the UC benefits.
 - (1) When an employe receives UC benefits which the employe is later required to repay based upon a determination of ineligibility, the insurer may not offset the workers' compensation benefits.
 - (2) When an employe's workers' compensation benefits have been offset by the amount received in UC benefits, and the employe is required to repay UC benefits based upon a determination of ineligibility, the insurer shall repay the employe for the amounts previously offset from the workers' compensation benefits. The employe may request that the insurer remit repayment directly to the Bureau of Unemployment Compensation Benefits and Allowances (BUCBA).

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

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

- (a) Workers' compensation benefits otherwise payable shall be offset by 50% of the net amount received in Social Security (old age) benefits. The offset shall only apply to amounts which an employe receives subsequent to the work-related injury. The offset may not apply to Social Security (old age) benefits which commenced prior to the work-related injury and which the employe continues to receive subsequent to the work-related injury.
- (b) The offset may not apply to benefits to which an employe may be entitled, but is not receiving.
- (c) The offset shall be applied on a weekly basis. To calculate the weekly offset, 50% of the net monthly Social Security (old age) benefit received by the employe shall be divided by 4.34.

§ 123.8. Offset for pension benefits generally.

- (a) Workers' compensation benefits otherwise payable shall be offset by the net amount an employe receives in pension benefits to the extent funded by the employer directly liable for the payment of workers' compensation.
- (b) The pension offset shall apply to amounts received from defined-benefit and defined-contribution plans.
- (c) The offset may not apply to pension benefits to which an employe may be entitled, but is not receiving.
- (d) In calculating the offset amount for pension benefits, investment income attributable to the employer's contribution to the pension plan shall be included on a prorata basis.

§ 123.9. Application of offset for pension benefits.

- (a) Offsets of amounts received from pension benefits shall be achieved on a weekly basis. If the employe receives the pension benefit on a monthly basis, the net amount contributed by the employer and received by the employe shall be divided by 4.34. The result is the amount of the weekly offset to the workers' compensation benefit.
- (b) When an employe receives a pension benefit in the form of a lump-sum payment, the actuarial equivalent of the lump-sum with respect to the annuity options (qualified joint and survivor annuity or life annuity) available at the time of the employe's receipt shall be used as the basis for calculating the offset to the workers' compensation benefit. The monthly annuity equivalent shall be divided by 4.34. The result shall be the offset to the workers' compensation benefit on a weekly basis.
- (c) Pension benefits which are rolled over into an IRA or other similarly restricted account may not offset workers' compensation benefits, so long as the employe does not withdraw or otherwise utilize the pension benefits from the restricted account while simultaneously receiving workers' compensation benefits from the liable employer.
- (d) If the employe, while receiving workers' compensation benefits from the liable employer, withdraws or otherwise utilizes pension benefits from the IRA or other similarly restricted account,

when the IRA or account is funded in whole or in part by the liable employer's contributions, the insurer is entitled to an offset to workers' compensation benefits.

- (1) If the employe begins receiving a monthly payment from the IRA or other similarly restricted account, the insurer shall receive an offset to the workers' compensation benefit equal to the offset the insurer would be entitled to if the employe were receiving a monthly pension benefit under subsection (a).
 - (2) If the employe withdraws or otherwise utilizes an amount from the IRA or other similarly restricted account which is greater than the actuarial equivalent of the lump sum with respect to the annuity options (qualified joint and survivor annuity or life annuity) available at the time of the employe's receipt, the insurer shall be entitled to an offset against future payments of workers' compensation benefits in an amount equal to the amount of the pension benefit withdrawn or otherwise utilized by the employe. The amount of the pension benefit withdrawn or otherwise utilized by the employe shall be divided by the weekly workers' compensation rate. The result shall be the number of weeks, and fraction thereof, the insurer may offset against future payments of workers' compensation benefits.
- (e) The employe shall report the subsequent receipt of pension benefits from the IRA or other similarly restricted account to the insurer on Forms LIBC-756 and LIBC-750, "Employee Report of Wages (Other Than Workers' Compensation Benefits Received)."

§ 123.10. Multiemployer pension fund offsets.

- (a) When the pension benefit is payable from a multi-employer pension plan, only that amount which is contributed by the employer directly liable for the payment of workers' compensation shall be used in calculating the offset to workers' compensation benefits.
- (b) To calculate the appropriate offset amount, the portion of the annuity purchased by the liable employer's contributions shall be as determined by the pension fund's actuary. The ratio of the portion of the annuity purchased by the liable employer's contributions to the total annuity shall be multiplied by the net benefit received by the employe from the pension fund on a weekly basis. The result is the amount of the offset to be applied to the workers' compensation benefit on a weekly basis.
- (c) If the employe receives the multi-employer pension benefit on a monthly basis, the net amount received by the employe shall be multiplied by the ratio of the liable employer's contribution to the pension plan on behalf of the employe and that product shall be divided by 4.34. The result is the amount of the offset to be applied to the workers' compensation benefit on a weekly basis.
- (d) If the employe receives the multi-employer pension benefit in a lump sum, the actuarial equivalent of the lump sum with respect to the annuity options (qualified joint and survivor annuity or life annuity) available at the time of the employe's receipt of the benefit shall be used as the basis for calculating the offset to the workers' compensation benefit. The ratio of the employer's contribution to the pension plan shall be multiplied by the monthly annuity value of the pension benefit. The result shall be divided by 4.34 to achieve the offset to the workers' compensation benefit on a weekly basis.

§ 123.11. Application of offset for severance benefits.

- (a) Workers' compensation benefits otherwise payable shall be offset by amounts an employe receives in severance benefits subsequent to the work-related injury. The offset may not apply to severance benefits to which an employe may be entitled, but is not receiving.
- (b) The net amount of any severance benefits shall offset workers' compensation benefits on a weekly basis except as provided in subsections (c) and (d).

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

Subchapter B. IMPAIRMENT RATINGS

§ 123.101. Purpose.

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

§ 123.102. IRE requests.

- (a) During the 60-day period subsequent to the expiration of the employe's receipt of 104 weeks of total disability benefits, the insurer may request the employe's attendance at an IRE. If the evaluation is scheduled to occur during this 60-day time period, the adjustment of the benefit status shall relate back to the expiration of the employe's receipt of 104 weeks of total disability benefits. In all other cases, the adjustment of the disability status shall be effective as of the date of the evaluation or as determined by the evaluating physician.
- (b) Absent agreement between the insurer and the employe, an IRE may not be performed prior to the expiration of the employe's receipt of 104 weeks of total disability benefits.
- (c) When an insurer requests the employe's attendance at an IRE during the 60-day period subsequent to the expiration of the employe's receipt of 104 weeks of total disability benefits and the employe fails, for any reason, to attend the IRE, when the failure results in the performance of the IRE more than 60 days beyond the expiration of the 104-week period, the adjustment of disability status shall relate back to the expiration of the employe's receipt of 104 weeks of total disability benefits.
- (d) The employe's receipt of 104 weeks of total disability benefits shall be calculated on a cumulative basis.
- (e) The insurer shall request the employe's attendance at the IRE in writing on Form LIBC-765, "Impairment Rating Evaluation Appointment," and specify therein the date, time and location of the evaluation and the name of the physician performing the evaluation, as agreed by the parties or designated by the Department. The request shall be made to the employe and employe's counsel, if known.
- (f) Consistent with section 306(a.2)(6) of the act (77 P. S. § 511.2), the insurer's failure to request the evaluation during the 60-day period subsequent to the expiration of the employe's receipt of 104 weeks of total disability benefits may not result in a waiver of the insurer's right to compel the employe's attendance at an IRE.
- (g) The insurer maintains the right to request and receive an IRE twice in a 12-month period. The request and performance of IREs may not preclude the insurer from compelling the employe's attendance at independent medical examinations or other expert interviews under section 314 of the act (77 P. S. § 651).

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

§ 123.103. Physicians.

- (a) Physicians performing IREs shall:
 - (1) Be licensed in this Commonwealth and certified by an American Board of Medical Specialties-approved board or its osteopathic equivalent.
 - (2) Be active in clinical practice at least 20 hours per week.
- (b) For purposes of this subchapter, the phrase "active in clinical practice" means the act of providing preventive care and the evaluation, treatment and management of medical conditions of patients on an ongoing basis.
- (c) Physicians chosen by employes to perform IREs, for purposes of appealing a previous adjustment of benefit status, shall possess the qualifications in subsection (a) and shall be active in clinical practice as specified in subsection (b).
- (d) In addition to the requirements of subsections (a) and (b), physicians designated by the Department to perform IREs shall meet training and certification requirements which may include, but are not limited to, one or more of the following:
 - (1) Required attendance at a Departmentally approved training course on the performance of evaluations under the AMA "Guides to the Evaluation of Permanent Impairment."
 - (2) Certification upon passage of a Departmentally approved examination on the AMA "Guides to the Evaluation of Permanent Impairment."
 - (3) Other requirements as approved by the Department.

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

- (a) The insurer is responsible for scheduling the initial IRE. Only the insurer may request that the Department designate an IRE physician.
- (b) The Department's duty to designate an IRE physician pertains only to the initial IRE. A list of Departmentally approved IRE physicians will be available upon request.
- (c) The request to designate a physician shall be made on Form LIBC-766, "Request for Designation of a Physician to Perform an Impairment Rating Evaluation."
- (d) Within 20 days of receipt of the designation request, the Department will designate a physician to perform the IRE.
- (e) The Department will provide the name and address of the physician designated to perform the IRE to the employe, the insurer and the attorneys for the parties, if known.

§ 123.105. Impairment rating determination.

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

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- (b) To ascertain an accurate percentage of the employe's whole body impairment, when the evaluating physician determines that the compensable injury incorporates more than one pathology, the evaluating physician may refer the employe to one or more physicians specializing in the specific pathologies which constitute the compensable injury. Any physician chosen by the evaluating physician to assist in ascertaining the percentage of whole body impairment shall possess the qualifications as specified in § 123.103(a) and (b) (relating to physicians). The referring physician remains responsible for determining the whole body impairment rating of the employe.
- (c) The physician performing the IRE shall complete Form LIBC-767, "Impairment Rating Determination Face Sheet" (Face Sheet), which sets forth the impairment rating of the compensable injury. The physician shall attach to the Face Sheet the "Report of Medical Evaluation" as specified in the AMA "Guides to the Evaluation of Permanent Impairment." The Face Sheet and report shall be provided to the employe, employe's counsel, if known, insurer and the Department within 30 days from the date of the impairment evaluation.
- (d) If the evaluation results in an impairment rating of less than 50%, the employe shall receive benefits partial in character. To adjust the status of the employe's benefits from total to partial, the insurer shall provide notice to the employe, the employe's counsel, if known, and the Department, on Form LIBC-764, "Notice of Change in Workers' Compensation Disability Status," of the following:
 - (1) The evaluation has resulted in an impairment rating of less than 50%.
 - (2) Sixty days from the date of the notice the employe's benefit status shall be adjusted from total to partial.
 - (3) The adjustment of benefit status does not change the amount of the weekly workers' compensation benefit.
 - (4) An employe may only receive partial disability benefits for a maximum of 500 weeks.
 - (5) The employe may appeal the adjustment of benefit status to a workers' compensation judge by filing a Petition for Review with the Department.
- (e) If the evaluation results in an impairment rating that is equal to or greater than 50%, the employe shall be presumed to be totally disabled and shall continue to receive total disability compensation. The presumption of total disability may be rebutted at any time by a demonstration of earning power in accordance with section 306(b)(2) of the act (77 P. S. § 512(b)(2)) or by a subsequent IRE which results in an impairment rating of less than 50%.
- (f) At any time during the receipt of 500 weeks of partial disability compensation, the employe may appeal the adjustment of benefit status to a workers' compensation judge by filing a Petition for Review.

Subchapter C. QUALIFICATIONS FOR VOCATIONAL EXPERTS APPROVED BY THE DEPARTMENT

§ 123.201. Purpose

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

§ 123.202. Qualifications.

To be an expert approved by the Department for the purpose of conducting earning power assessment

interviews, the individual shall possess a minimum of one of the following:

- (1) Both of the following:
 - (i) Certification by one of the following Nationally recognized professional organizations:
 - (A) The American Board of Vocational Experts.
 - (B) The Commission on Rehabilitation Counselor Certification.
 - (C) The Commission on Disability Management Specialists Certification.
 - (D) The National Board of Certified Counselors.
 - (E) Other Nationally recognized professional organizations approved by the Department.
 - (ii) One year experience in analyzing labor market information and conditions, industrial and occupational trends, with primary duties providing actual vocational rehabilitation services, which include the following:
 - (A) Job seeking skills.
 - (B) Job development.
 - (C) Job analysis.
 - (D) Career exploration.
 - (E) Placement of individuals with disabilities.
 - (F) Vocational testing and assessment.
- (2) Certification by a Nationally recognized professional organization specified in paragraph (1) (i) under the direct supervision of an individual possessing the criteria in paragraph (1).
- (3) Possession of a Bachelor's degree or a valid license issued by the Department of State's Bureau of Professional and Occupational Affairs, as long as the individual is under the direct supervision of an individual possessing the criteria in paragraph (1).
- (4) At least 5 years experience primarily in the workers' compensation field prior to August 23, 1996, as a vocational evaluator, with experience in analyzing labor market information and conditions, industrial and occupational trends, with primary duties providing actual vocational rehabilitation services, which include, but are not limited to, the following:
 - (i) Job seeking skills.
 - (ii) Job development.
 - (iii) Job analysis.
 - (iv) Career exploration.
 - (v) Placement of individuals with disabilities.
 - (vi) Vocational testing and assessment.

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§ 123.203. Credibility determinations.

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

Subchapter D. EARNING POWER DETERMINATIONS

§ 123.301. Employer job offer obligation.

- (a) For claims for injuries suffered on or after June 24, 1996, if a specific job vacancy exists within the usual employment area within this Commonwealth with the liable employer, which the employe is capable of performing, the employer shall offer that job to the employe prior to seeking a modification or suspension of benefits based on earning power.
- (b) The employer's obligation to offer a specific job vacancy to the employe commences when the insurer provides the notice to the employe required by section 306(b)(3) of the act (77 P. S. § 512(b)(3)) and shall continue for 30 days or until the filing of a Petition for Modification or Suspension, whichever is longer. When an insurer files a Petition for Modification or Suspension which is not based upon a change in medical condition, the employer's obligation to offer a specific job vacancy commences at least 30 days prior to the filing of the petition.
- (c) The employer's duty under subsections (a) and (b) may be satisfied if the employer demonstrates facts which may include the following:
 - (1) The employe was notified of a job vacancy and failed to respond.
 - (2) A specific job vacancy was offered to the employe, which the employe refused.
 - (3) The employer offered a modified job to the employe, which the employe refused.
 - (4) No job vacancy exists within the usual employment area.
- (d) When more than one job which the employe is capable of performing becomes available, the employer maintains the right to select which job will be offered to the employe.
- (e) The employer's duty under subsections (a) and (b) does not require the employer to hold a job open for a minimum of 30 days. Job offers shall be made consistent with the employer's usual business practice. If the making of job offers is controlled by the provisions of a collective bargaining agreement, the offer shall be made consistent with those provisions.
- (f) If the employer has presented evidence that no job vacancy exists, the employe may rebut the employer's evidence by demonstrating facts which may include the following:
 - (1) During the period in which the employer has or had a duty to offer a specific job, the employer is or was actively recruiting for a specific job vacancy that the employe is capable of performing.
 - (2) During the period in which the employer has or had a duty to offer a specific job, the employer posted or announced the existence of a specific job vacancy, that the employe is capable of performing, which the employer intends to fill.
- (g) A job may not be considered vacant if the employe's ability to fill the position was precluded by any applicable collective bargaining agreement.

§ 123.302. Evidence of earning power.

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

Subchapter E. COLLECTIVE BARGAINING

§ 123.401. Use of ADR systems.

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

§ 123.402. Forms and filing requirements.

- (a) If the employer and the recognized or certified and exclusive representative of its employes agree to establish an ADR system, a copy of the portion of the CBA which establishes the ADR system shall be provided to the Governor's Office of Labor-Management Cooperation in the Department.
- (b) The standard forms and filing requirements of the act which reflect the voluntary action or agreement of the parties remain in effect for parties participating in an ADR system under section 450 of the act (77 P. S. § 1000.6). The forms exclusively pertaining to filings before a workers' compensation judge are inapplicable to parties participating in an ADR system.
- (c) Documents submitted to the Department under this subchapter shall clearly indicate, by notation on the top page of the document, that a section 450 ADR system governs the disposition of the matter.
- (d) Final determinations rendered by means of an ADR system shall be documented and a copy of the determination shall be submitted to the parties and to the Department.

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

- (a) Once established by a CBA, an ADR system shall be the exclusive system for resolving claims for work-related injuries during the existence of the CBA or longer, if the CBA provides for the continued operation of the ADR system at the expiration of the CBA.
- (b) When an ADR system governing a work-related injury is no longer in effect, resolution of claims shall be fully subject to the act, including review by a workers' compensation judge.

§ 123.404. Effect and appeal of ADR final determinations.

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

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Subchapter F. EMPLOYE REPORTING AND VERIFICATION REQUIREMENTS

§ 123.501. Reporting requirement.

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

§ 123.502. Verification.

- (a) Insurers may submit Form LIBC-760, "Employee Verification of Employment, Self-employment or Change in Physical Condition," to the employe and employe's counsel, if known, to verify, no more than once every 6 months, that the status of the employe's entitlement to receive compensation has not changed.
- (b) Form LIBC-760 shall be delivered to the employe in person or consistent with section 406 of the act.
- (c) The employe shall complete and return form LIBC-760 to the insurer within 30 days of receipt of the form.
- (d) If the employe fails to comply with subsection (c), the insurer may suspend payments of wage-loss benefits until Form LIBC-760 is returned by the employe.
- (e) To suspend payments of compensation due to the employe's failure to comply with subsection (c), the insurer shall provide written notice to the employe, the employe's counsel, if known, and the Department, on Form LIBC-762, "Notice of Suspension for Failure to Return Form LIBC-760 (Employee Verification of Employment, Self-employment or Change in Physical Condition)" of the following:
 - (1) The workers' compensation benefits have been suspended because of the employe's failure to return the verification form within the 30-day statutorily prescribed time period.
 - (2) The workers' compensation benefits shall be reinstated by the insurer, effective upon receipt of the completed verification form.
 - (3) The employe has the right to challenge the suspension of benefits by filing a petition for reinstatement with the Department.
- (f) Upon receipt of the completed verification form, the insurer shall reinstate the workers' compensation benefits for which the employe is eligible. The insurer shall provide written notice to the employe, employe's counsel, if known, and the Department, on Form LIBC-763, "Notice of Reinstatement of Workers' Compensation Benefits," that the employe's workers' compensation benefits have been reinstated due to the return of the completed verification form. The notice shall further indicate the date the verification form was received by the insurer and the date of reinstatement of the workers' compensation benefits.
- (g) Employes are not entitled to payments of workers' compensation during periods of noncompliance with subsection (c).

Subchapter G. INFORMAL CONFERENCE

§ 123.601. Representation of corporation at informal conference.

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

Subchapter H. USE OF OPTICALLY SCANNED DOCUMENTS

§ 123.701. Use of optically scanned documents.

- (a) The Bureau may optically scan original documents, or make other images or paper copies which accurately reproduce the originals, and may dispose of originals so copied.
- (b) Copies made under this section, and certified by the custodian of records for the Bureau, are admissible in evidence in a proceeding with the same effect as though they were an original.

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CHAPTER 127. WORKERS' COMPENSATION MEDICAL COST CONTAINMENT

Subchapter B. MEDICAL FEES AND REVIEW

CALCULATIONS

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

- (a) Payments for services rendered by chiropractors shall be made for those services permitted by the Chiropractic Practice Act (63 P. S. § 625.101 - 625.1106).
- (b) Payments for spinal manipulation procedures by chiropractors shall be based on the Medicare fee schedule for HCPCS codes 98940 - 98943, multiplied by 113%.
- (c) Payments for physiological therapeutic procedures by chiropractors shall be based on the Medicare fee schedule for HCPCS codes 97010 - 97799, multiplied by 113%.
- (d) Payments shall be made for documented office visits and shall be based on the Medicare fee schedule for HCPCS codes 99201 - 99205 and 99211 - 99215, multiplied by 113%.
- (e) Payment shall be made for an office visit provided on the same day as another procedure only when the office visit represents a significant and separately identifiable service performed in addition to the other procedure. The office visit shall be billed under the proper level HCPCS codes 99201 - 99215, and shall require the use of the procedure code modifier “-25” (indicating a Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure).

BILLING TRANSACTIONS

§ 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.

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

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

- (a) Providers seeking review of fee disputes shall file the original and one copy of a form prescribed by the Bureau as an application for fee review. The application shall be filed no more than 30 days following notification of a disputed treatment or 90 days following the original billing date of the treatment which is the subject of the fee dispute, whichever is later. The form shall be accompanied by documentation required by § 127.253 (relating to application for fee review — documents required generally).
- (b) Providers shall serve a copy for the application for fee review, and the attached documents, upon the insurer. Proof of service shall accompany the application for fee review and shall indicate the person served, the date of service and the form of service.
- (c) Providers shall send the application for fee review and all related attachments to the address for the Bureau listed on the application form.
- (d) The time for filing an application for fee review will be tolled if the insurer has the right to suspend payment to the provider due to a dispute regarding the reasonableness and necessity of the treatment under Subchapter C (relating to medical treatment review).

Subchapter C. MEDICAL TREATMENT REVIEW

UR — GENERAL REQUIREMENTS

§ 127.401. Purpose/review of medical treatment.

- (a) Section 306(f.1)(6) of the act (77 P. S. § 531(6)) provides a UR process, intended as an impartial review of the reasonableness or necessity of medical treatment rendered to, or proposed for, work-related injuries and illnesses.
- (b) UR of medical treatment shall be conducted only by those organizations authorized as UROs by the Secretary, under the process in §§ 127.651 - 127.670 (relating to authorization of UROs and PROs).
- (c) UR may be requested by or on behalf of the employer, insurer or employee.
- (d) A party, including a health care provider, aggrieved by the UR determination, may file a petition for review of UR, to be heard and decided by a workers' compensation judge.

§ 127.404. Prospective, concurrent and retrospective review.

- (a) UR of treatment may be prospective, concurrent or retrospective, and may be requested by any party eligible to request UR under § 127.401(c) (relating to purpose/review of medical treatment).
- (b) If an insurer or employer seeks retrospective review of treatment, the request for UR shall be filed within 30 days of the receipt of the bill and medical report for the treatment at issue. Failure to comply with the 30-day time period shall result in a waiver of retrospective review. If the

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insurer is contesting liability for the underlying claim, the 30 days in which to request retrospective UR is tolled pending an acceptance or determination of liability.

- (c) If an employe files a request for UR of treatment, the Bureau will confirm whether the insurer is liable for the underlying alleged work injury. The Bureau will process the UR request only when workers' compensation liability for the underlying injury has been accepted or determined.
- (d) If an employe files a request for UR of prospective treatment which satisfies the requirements of subsection (c), the Bureau will determine whether the insurer is denying payment for the treatment.
 - (1) The Bureau will send a copy of the employe's request for UR to the insurer, together with a written notice asking the insurer whether it will accept payment for the treatment or is denying payment for the treatment. The insurer shall respond in writing to the Bureau's written notice within 7 days of receipt of the notice.
 - (2) If the insurer responds that it is willing to accept payment for the treatment, the Bureau will not process the employe's request for UR. After the treatment at issue has been provided, the insurer may not request, and the Bureau will not process, a retrospective UR on the same treatment. The insurer shall pay for the treatment as if there had been an uncontested UR determination finding the treatment to be reasonable or necessary.
 - (3) If the insurer is denying payment for the treatment, the insurer shall state the reasons for the denial in its written response. If no reasons are stated for the denial, or if the insurer's written response to the Bureau notice is untimely, the insurer shall pay for the cost of the UR and pay for treatment found to be reasonable or necessary by an uncontested UR determination.
 - (4) If the insurer responds in writing to the Bureau's notice by denying a causal relationship between the work-related injury and the treatment, the Bureau will not process the employe's UR request until the underlying liability is either accepted by the insurer or determined by a Workers' Compensation judge.

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

- (a) In medical only cases, when an insurer is paying for an injured worker's medical treatment but has not either filed documents with the Bureau admitting liability for a work-related injury nor has there been a determination to the effect, the insurer may still seek review of the reasonableness or necessity of the treatment by filing a request for UR.
- (b) If the insurer files a request for UR in a medical only case, the insurer is responsible for paying for the costs of the UR.
- (c) If the insurer files a request for UR in a medical only case, then the insurer shall be liable to pay for treatment found to be reasonable or necessary by an uncontested UR determination.

UR — 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.

§ 127.452. Requests for UR — filing and service.

- (a) A party seeking UR of treatment rendered under the act shall file the original and 8 copies of a

form prescribed by the Bureau as a request for UR. All information required by the form shall be provided. If available, the filing party shall attach authorizations to release medical records of the providers listed on the request.

- (b) The request for UR shall be served on all parties and their counsel, if known, and the proof of service on the form shall be executed. If the proof of service is not executed, the request for UR will be returned by the Bureau.
- (c) Requests for UR shall be sent to the Bureau at the address listed on the form.
- (d) The request for UR shall identify the provider under review. Except as specified in subsection (e), the provider under review shall be the provider who rendered the treatment or service which is the subject of the UR request.
- (e) When the treatment or service requested to be reviewed is anesthesia, incident to surgical procedures, diagnostic tests, prescriptions or durable medical equipment, the request for UR shall identify the provider who made the referral, ordered or prescribed the treatment or service as the provider under review.

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

- (a) The Bureau will randomly assign a properly filed request for UR to an authorized URO.
- (b) The Bureau will send a notice of assignment of the request for UR to the URO; the employee; the employer or insurer; the health care provider under review; and the attorneys for the parties, if known.

§ 127.454. Requests for UR — reassignment.

- (a) If a URO is unable, for any reason, to perform a request for UR assigned to it by the Bureau, the URO shall, within 5 days of receipt of the assignment, return the request for UR to the Bureau for reassignment.
- (b) A URO may not directly reassign a request for UR to another URO.
- (c) A URO shall return a request for UR assigned to it by the Bureau if the URO has a conflict of interest with the request, as set out in § 127.455 (relating to requests for UR — conflicts of interest).

§ 127.455. Requests for UR — conflicts of interest.

- (a) A URO shall be deemed to have a conflict of interest and shall return a request for UR to the Bureau for reassignment if one or more of the following exist:
 - (1) The URO has a previous involvement with the patient or with the provider under review, regarding the same underlying claim.
 - (2) The URO has performed precertification functions in the same matter.
 - (3) The URO has provided case management services in the same matter.
 - (4) The URO has provided vocational rehabilitation services in the same matter.
 - (5) The URO is owned by or has a contractual arrangement with any party subject to the review.

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

§ 127.456. Requests for UR — withdrawal.

- (a) A party who wishes to withdraw a request for UR shall notify the Bureau of the withdrawal in writing. The withdrawal notice may not be sent directly to the URO.
- (b) The Bureau will promptly notify the URO of the withdrawal.
- (c) The insurer or employer shall pay the costs incurred by the URO prior to the withdrawal.
- (d) A withdrawal of a request for UR shall be with prejudice.

§ 127.457. Time for requesting medical records.

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

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

- (a) A request for UR shall be deemed complete upon receipt of the medical records or 35 days from the date of the notice of assignment, whichever is earlier.
- (b) A URO shall complete its review, and render its determination, within 30 days of a completed request for UR.

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

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

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

- (a) Each determination rendered by a URO on the merits shall include a form prescribed by the Bureau as a medical treatment review determination face sheet and the reviewer's report. The face sheet shall be signed by an authorized representative of the URO.
- (b) When a determination is rendered against the provider under review on the basis that no records were supplied by the provider, the determination shall consist only of the face sheet. However, in these cases, the face sheet shall clearly indicate that the basis for the decision is the failure of the provider under review to supply records to the URO.
- (c) The URO's determination, consisting of both the face sheet and the reviewer's report, shall be served on the employe, the insurer or employer, the provider under review, the attorneys for the parties, if known, and the Bureau.
- (d) The URO shall also serve a copy of a petition for review of a UR determination on all parties and their attorneys, if known.
- (e) Service shall be made by certified mail, return receipt requested and shall be made on the same date as is entered on the appropriate line of the face sheet.

§ 127.477. Payment for request for UR.

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

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

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

§ 127.501 - 127.515. (Reserved).

UR — PETITION FOR REVIEW

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

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

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

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

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

- (a) The Bureau will assign the petition for review to a workers' compensation judge. The Bureau will serve the notice of assignment and the petition for review upon the URO, the employe, the employer or insurer, the health care provider under review, and the attorneys for the parties, if known.
- (b) When a petition for review is filed in a case already in litigation before a workers' compensation judge, the Bureau will assign the petition for review to the workers' compensation judge who is hearing the case-in-chief.
- (c) Before assigning a petition for review, the Bureau will review the petition to ensure that a UR has been filed and a determination has been rendered.

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

- (a) Upon the workers' compensation judge's own motion, or motion of any party to the proceeding, the workers' compensation judge may order the URO to forward all medical records obtained for its review to the workers' compensation judge. The URO shall forward all records within 10 days of the date of the workers' compensation judge's order.
- (b) When a petition for review has been filed, the Bureau will forward the URO report to the workers' compensation judge assigned to the case.
- (c) An authorized agent of the URO shall sign a verification stating that, to the best of his knowledge, the complete set of unaltered records obtained by the URO is being transmitted to the workers' compensation judge.

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

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

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

Subchapter D. EMPLOYER LIST OF DESIGNATED PROVIDERS

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

- (a) Employers have the option to establish a list of designated health care providers under section 306(f.1)(1)(i) of the act (77 P. S. § 531(1)(i)).
- (b) If an employer has established a list of providers which meets the requirements of the act and this subchapter, an employe with a work-related injury or illness shall seek treatment with one of the designated providers from the list. The employe shall continue to treat with the same provider or another designated provider for 90 days from the date of the first visit for the treatment of the work injury or illness.
- (c) The employer may not require treatment with any one specific provider on the list, nor may the employer restrict the employe from switching from one designated provider to another designated provider.
- (d) An employe may not be required to obtain emergency medical treatment from a listed provider. However, once emergency conditions no longer exist, the injured employe shall treat with a listed provider for the remainder of the 90-day period.
- (e) If an employer's list of designated providers fails to comport with the act and this subchapter, the employe shall have the right to treat with a health care provider of the employe's choice from the time of the initial visit.
- (f) If an employer chooses not to establish a list of designated providers, the employe shall have the right to seek medical treatment from any provider from the time of the initial visit.
- (g) If a designated provider prescribes invasive surgery for the employe, the employe may seek an additional opinion from any health care provider of the employe's choice. If the additional opinion differs from the opinion of the designated provider and the additional opinion provides a specific and detailed course of treatment, the employe shall determine which course of treatment to follow. If the employe opts to follow the course of treatment outlined by the additional opinion, the treatment shall be performed by one of the health care providers on the employer's designated list for 90 days from the date of the first visit to the provider of the additional opinion.

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

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

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- (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 employees.
 - (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 employee who has already commenced the 90-day treatment period.

§ 127.755. Required notice of employe rights and duties.

- (a) If a list of designated providers is established, the employer shall provide a clearly written notice to an injured employe of the employe's rights and duties under section 306(f.1)(1)(i) of the act (77 P. S. § 531(1)(i)).
- (b) The contents of the written notice shall, at a minimum, contain the following conditions:
 - (1) The employe has the duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.
 - (2) The employe has the right to have all reasonable medical supplies and treatment related to the injury paid for by the employer as long as treatment is obtained from a designated provider during the 90-day period.
 - (3) The employe has the right, during this 90-day period, to switch from one health care provider on the list to another provider on the list, and that all the treatment shall be paid for by the employer.
 - (4) The employe has the right to seek treatment from a referral provider if the employe is referred to him by a designated provider, and the employer shall pay for the treatment rendered by the referral provider.
 - (5) The employe has the right to seek emergency medical treatment from any provider, but that subsequent nonemergency treatment shall be by a designated provider for the remainder of the 90-day period.
 - (6) The employe has the right to seek treatment or medical consultation from a nondesignated provider during the 90-day period, but that these services shall be at the employe's expense for the applicable 90 days.
 - (7) The employe has the right to seek treatment from any health care provider after the 90-day period has ended, and that treatment shall be paid for by the employer, if it is reasonable and necessary.

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- (8) The employe has the duty to notify the employer of treatment by a nondesignated provider within 5 days of the first visit to that provider. The employer may not be required to pay for treatment rendered by a nondesignated provider prior to receiving this notification. However, the employer shall pay for these services once notified, unless the treatment is found to be unreasonable by a URO, under Subchapter C (relating to medical treatment review).
- (9) The employe has the right to seek an additional opinion from any health care provider of the employe's choice when a designated provider prescribes invasive surgery for the employe. If the additional opinion differs from the opinion of the designated provider and the additional opinion provides a specific and detailed course of treatment, the employe shall determine which course of treatment to follow. If the employe opts to follow the course of treatment outlined by the additional opinion, the treatment shall be performed by one of the health care providers on the employer's designated list for 90 days from the date of the first visit to the provider of the additional opinion.
- (c) The written notice to an employe of the employe's rights and duties under this section shall be provided at the time the employe is hired and immediately after the injury, or as soon thereafter as possible under the circumstances of the injury. If the employe's injuries are so severe that emergency care is required, notice of the employe's rights and duties shall be given as soon after the occurrence of the injury as is practicable.
- (d) The employer's duty under subsection (a) shall be evidenced by the employe's written acknowledgment of having been informed of and having understood the notice of the employe's rights and duties. Any failure of the employer to provide and evidence the notification relieves the employe from any duties specified in the notice, and the employer remains liable for all treatment rendered to the employe. However, an employe may not refuse to sign an acknowledgment to avoid duties specified in the notice.

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

Subchapter C. FORMAL PROCEEDINGS

SUPERSEDEAS

§ 131.49. Disposition of automatic request for special supersedeas.

- (a) The filing of a petition alleging full recovery, accompanied by a physician's affidavit to that effect, which was prepared in connection with an examination of the employe no more than 21 days from the filing of the petition, shall act as an automatic request for supersedeas.
- (b) A special supersedeas hearing will be held within 21 days of the assignment of the petition filed under this section.
- (c) The workers' compensation judge shall approve the request for supersedeas if prima facie evidence of a change in the medical status or of any other fact which would serve to modify or terminate the payment of compensation is submitted at the hearing, unless the employe establishes by a preponderance of the evidence a likelihood of prevailing on the merits of the employe's defense. In making this determination the workers' compensation judge shall consider the physician's affidavit alleging full recovery and may consider the following:
 - (1) The report of the physician.
 - (2) The testimony of a party or witness.
 - (3) The records of a physician, hospital or clinic or other similar entity.
 - (4) The written statements or reports of another person expected to be called by a party at the hearing of the case.
 - (5) Other evidence relevant to the request for supersedeas.
- (d) If the judge to whom the special supersedeas request has been assigned fails to hold a hearing within 21 days of assignment of the request to the judge or fails to issue a written order within 7 days of the hearing of the supersedeas request, the automatic request for supersedeas shall be deemed denied. The automatic request for supersedeas shall remain denied until the judge issues a written order granting the supersedeas, in whole or in part.

§ 131.50. Return to work — modification or suspension.

- (a) If an employe returns to work, the insurer may modify or suspend the workers' compensation benefits.
- (b) The insurer shall complete and file Form LIBC-751, "Notification of Suspension or Modification Pursuant to §§ 413(C) & (D)." The form shall be provided to the employe, employe's counsel, if known, and the Department within 7 days of the effective date of the suspension or modification of the workers' compensation benefits.
- (c) When the insurer previously modified or suspended the employe's benefits under section 413(c) or (d) of the act (77 P. S. § 774.2 and § 774.3), to effectuate a subsequent modification or suspension of the employe's workers' compensation benefits, the insurer shall file the form under subsection (b), indicating the change in the employe's wages and corresponding change in the employe's workers' compensation benefits.

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§ 131.50a. Employee request for special supersedeas hearing under section 413(c) and (d) of the act.

- (a) This section governs the disposition of an employee's request for a special supersedeas hearing made in connection with a challenge to the suspension or modification of workers' compensation benefits under section 413(c) and (d) of the act (77 P. S. §§ 774.2 and 774.3).
- (b) A special supersedeas hearing will be held within 21 days of the employee's filing of the notice of challenge.
- (c) The workers' compensation judge to whom the notice of challenge has been assigned will issue a written order on the challenge within 14 days of the hearing.
- (d) If the judge fails to hold a hearing within 21 days or fails to issue a written order approving the suspension or modification of benefits within 14 days of the hearing, the insurer shall reinstate the employee's workers' compensation benefits at the weekly rate the employee received prior to the insurer's suspension or modification of benefits under section 413(c) or (d) of the act.

[Editor's Note: Regulations promulgated for Act 44 of 1993.]

TITLE 34. LABOR AND INDUSTRY

PART VIII. BUREAU OF WORKERS' COMPENSATION

CHAPTER 127. WORKERS' COMPENSATION MEDICAL COST CONTAINMENT

Subchapter A. PRELIMINARY PROVISIONS

§ 127.1. Purpose.

This chapter implements those sections of the act that relate to payments made by insurers or self-insured employers for medical treatment and the review of medical treatment provided to employees 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.

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- (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 employees.

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, employees 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.

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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

§ 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.

§ 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

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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).

§ 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%.

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

[Editor's Note: See corresponding section in Act 57 regulations.]

§ 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).

§ 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%.

§ 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%.

§ 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).

§ 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.

§ 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

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Medicare payment adjustments published in the *Federal Register*. The effective date for these changes under the Medicare Program shall also be the effective date for the changes under the act.

- (c) If the amount of the DRG reimbursement changes during a patient's stay, the applicable reimbursement rate on the date of discharge shall be used to calculate payment under the act.
- (d) If a patient was admitted prior to August 31, 1993, the act's medical fee caps may not apply.

§ 127.112. 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.

§ 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.

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- (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

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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.

§ 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).

§ 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.

§ 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.

§ 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.

§ 127.118. RCCs — generally.

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

§ 127.119. Payments for services using RCCs.

- (a) Payments for services listed in § 127.117(1) (relating to outpatient acute care providers, specialty hospitals and other cost reimbursed providers not subject to the Medicare fee schedule) shall be

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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).

§ 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).

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

§ 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.

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- (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.

§ 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%.

§ 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.

§ 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).

§ 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.

§ 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.

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- (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.

§ 127.127. Mergers and acquisitions.

- (a) When a merger, acquisition or change in ownership results in the elimination of the assets of a merged or acquired entity, and consolidation of the assets into the surviving entity, payments shall be determined by reference to the relevant cost reports and other relevant data of the surviving entity, except as noted in subsection (b).
- (b) If services were provided at the merged or acquired provider that were not provided at the surviving provider (prior to merger or acquisition) and therefore were not reported as a cost center on its most recently audited Medicare cost report, the per diem rates and RCCs to be used for determining payment for these services shall be obtained from the most recently audited cost report of the merged or acquired provider.

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

- (a) Acute care provided in a trauma center or a burn facility is exempt from the medical fee caps, and shall be paid based on 100% of usual and customary charges if the following apply:
 - (1) The patient has an immediately life-threatening injury or urgent injury.
 - (2) Services are provided in an acute care facility that is one of the following:
 - (i) A level I or level II trauma center, accredited by the Pennsylvania Trauma Systems Foundation under the Emergency Medical Services Act (35 P. S. §§ 6921 - 6938).
 - (ii) A burn facility which meets the service standards of the American Burn Association.
- (b) Basic or advanced life support services, as defined and licensed under the Emergency Medical Services Act, provided in the transport of patients to trauma centers or burn facilities under subsection (a) are also exempt from the medical fee caps, and shall be paid based on 100% of usual and customary charges.
- (c) If the patient is initially transported to the trauma center or burn facility in accordance with the American College of Surgeons' (ACS) triage guidelines, payment for transportation to the trauma

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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.

§ 127.129. Out-of-State medical treatment.

- (a) When injured employees 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 employees 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.

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- (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.

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

- (a) Changes in Medicare reimbursement rates prior to January 1, 1995, shall be reflected in calculations of payments to providers under the act.
- (b) The effective date for these rate changes under the Medicare Program shall also be the effective date for the fee changes under the act. The new rates shall apply to all treatment and services provided on and after the effective date of the rate change.

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

- (a) Changes in Medicare reimbursement rates on and after January 1, 1995, may not be included in calculations of payments to providers under Act 44.
- (b) Medical fee updates on and after January 1, 1995, shall be calculated based on the percentage changes in the Statewide average weekly wage, as published annually by the Department in the *Pennsylvania Bulletin*. These updates shall be effective on January 1 of each year, and they shall be cumulative.

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

- (a) On and after January 1, 1995, outpatient providers whose payments under the act are based on the Medicare fee schedule under §§ 127.103 - 127.108 shall be paid as follows: the amount of payment authorized shall be frozen on December 31, 1994, and updated annually by the percentage change in the Statewide average weekly wage.
- (b) On and after January 1, 1995, adjustments and modifications by HCFA relating to a change in description or renumbering of any HCPCS code will be incorporated into the basis for determining the amount of payment as frozen in subsection (a) for services rendered under the act.
- (c) On and after January 1, 1995, payment rates under the act for new HCPCS codes will be based on the rates allowed in the Medicare fee schedule on the effective date of the new codes. These payment rates shall be frozen immediately, and thereafter updated annually by the percentage change in the Statewide average weekly wage.

§ 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.

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- (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.

§ 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.

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- (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.

§ 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.

§ 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.

§ 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.

§ 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.

§ 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).

§ 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.

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

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

BILLING TRANSACTIONS

§ 127.201. Medical bills — standard forms.

- (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).

§ 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.

§ 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.

§ 127.204. Fragmenting or unbundling of charges by providers.

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

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

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

§ 127.206. Payment of medical bills — request for additional documentation.

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

§ 127.207. Downcoding by insurers.

- (a) Changes to a provider's codes by an 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).

§ 127.208. Time for payment of medical bills.

[Editor's Note: See corresponding section in Act 57 regulations.]

§ 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."

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§ 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).

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.

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

[Editor's Note: See corresponding sections in Act 57 regulations.]

§ 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:

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- (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.

§ 127.254. Downcoding disputes.

- (a) When changes in procedure codes are the basis for a fee dispute, the Bureau will give the provider and the insurer the opportunity to produce copies of written communications concerning the changes in procedure codes.
- (b) If an insurer has not complied with § 127.207 (relating to downcoding by insurers) the Bureau will resolve downcoding disputes in favor of the provider.

§ 127.255. Premature applications for fee review.

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).

§ 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

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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.

§ 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.

§ 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

§ 127.401. Purpose/review of medical treatment.

[Editor's Note: See corresponding sections in Act 57 regulations.]

§ 127.402. Treatment subject to review.

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

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§ 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.

[Editor's Note: See corresponding sections in Act 57 regulations.]

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

[Editor's Note: See corresponding sections in Act 57 regulations.]

§ 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.

§ 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.

[Editor's Note: See corresponding sections in Act 57 regulations.]

§ 127.452. Requests for UR — filing and service.

[Editor's Note: See corresponding sections in Act 57 regulations.]

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

[Editor's Note: See corresponding sections in Act 57 regulations.]

§ 127.454. Requests for UR — reassignment.

[Editor's Note: See corresponding sections in Act 57 regulations.]

§ 127.455. Requests for UR — conflicts of interest.

[Editor's Note: See corresponding sections in Act 57 regulations.]

§ 127.456. Requests for UR — withdrawal.

[Editor's Note: See corresponding sections in Act 57 regulations.]

§ 127.457. Time for requesting medical records.

[Editor's Note: See corresponding sections in Act 57 regulations.]

§ 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

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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.

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

[Editor's Note: See corresponding sections in Act 57 regulations.]

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

[Editor's Note: See corresponding sections in Act 57 regulations.]

§ 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.

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

§ 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.

§ 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.

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§ 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.

[Editor's Note: See corresponding sections in Act 57 regulations.]

§ 127.477. Payment for requests for UR.

[Editor's Note: See corresponding sections in Act 57 regulations.]

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.

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

[Editor's Note: See corresponding section in Act 57 regulations.]

UR — RECONSIDERATION

[Editor's Note: §§ 127.501 - 127.515 have been deleted pursuant to Act 57.]

UR — PETITION FOR REVIEW

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

[Editor's Note: See corresponding sections in Act 57 regulations.]

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

[Editor's Note: See corresponding sections in Act 57 regulations.]

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

[Editor's Note: See corresponding sections in Act 57 regulations.]

§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.

[Editor's Note: See corresponding sections in Act 57 regulations.]

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

[Editor's Note: See corresponding sections in Act 57 regulations.]

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).

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§ 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.

§ 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.

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§ 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.

§ 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 courses 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

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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.

§ 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.

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- (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.

§ 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).

§ 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.

§ 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.

§ 127.656. General qualifications.

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

§ 127.657. Local business office.

A URO or PRO shall have a business office located within this Commonwealth which is staffed and

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open at a minimum from 9 a.m. - 5 p.m. Monday through Friday, except for legal holidays.

§ 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.

§ 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.

§ 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.

§ 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.

§ 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.

§ 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.

§ 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.

§ 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.

§ 127.666. Annual reports.

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

§ 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.

§ 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.

§ 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).

§ 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.

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- (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.

Subchapter D. EMPLOYER LIST OF DESIGNATED PROVIDERS

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

[Editor's Note: See corresponding sections in Act 57 regulations.]

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

[Editor's Note: See corresponding sections in Act 57 regulations.]

§ 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.

[Editor's Note: See corresponding section in Act 57 regulations.]

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ADDITIONAL PROVISIONS OF THE ACT

The following provisions were enacted as part of Act 57 of 1996:

Sec 30 For the purpose of initial filing only, notwithstanding any other provisions of this act, the following shall apply:

- (1) No later than 45 days after the effective date of this section, the Insurance Commissioner shall appoint an independent actuary to provide an estimate of the total change in workers' compensation loss-cost resulting from implementation of this act and resulting from implementation of the act of July 2, 1993 (P.L.190, No.44), entitled "An act amending the act of June 2, 1915 (P.L.736, No.338), entitled, as reenacted and amended, 'An act defining the liability of an employer to pay damages for injuries received by an employe in the course of employment; establishing an elective schedule of compensation; providing procedure for the determination of liability and compensation thereunder; and prescribing penalties,' adding and amending certain definitions; redesignating referees as workers' compensation judges; further providing for contractors, for insurance and self-insurance, for compensation and for payments for medical services; providing for coordinated care organizations; further providing for procedures for the payment of compensation and for medical services and for procedures of the department, referees and the board; adding provisions relating to insurance, self-insurance pooling, self-insurance guaranty fund, health and safety and the prevention of insurance fraud; further providing for certain penalties; making repeals; and making editorial changes," and an estimate of any other change attributable to data not considered in any previous loss-cost filing. The fee for this independent actuary shall be borne by the Workmen's Compensation Administration Fund. In developing the estimate, the independent actuary shall consider all of the following:
 - (i) The most recent policy year unit statistical and financial loss-cost data available after policy year 1993. Notwithstanding any other provision of this section, for purposes of this subparagraph, the Coal Mine Compensation Rating Bureau shall submit the most recent accident or calendar year statistical and financial loss-cost data available after accident or calendar year 1993.
 - (ii) The standards set forth in section 704 of the act, as applicable.
 - (iii) Any other relevant factors within and outside this Commonwealth in accordance with sound actuarial principles.
- (2) No later than 15 days after the effective date of this section, each insurer, including the State Workmen's Insurance Fund, shall file loss data as required under paragraph (1) with its rating organization. For failure to comply, the commissioner shall impose an administrative penalty of \$1,000 for every day that this data is not provided in accordance with this paragraph.
- (3) No later than 45 days after the effective date of this section, each rating organization shall provide to the independent actuary, the commissioner and the small business advocate aggregate loss-cost data equal to or greater than 75% of the total data expected from all insurers, including the State Workmen's Insurance Fund. For failure to comply by any rating organization, the commissioner shall impose an administrative penalty of \$1,000 for every day that the data is not provided in accordance with this paragraph unless caused by the late reporting of any insurer. The commissioner shall impose an administrative fine of \$1,000 upon any insurer whose late reporting of data causes such a delay, for every day beyond the required time frame of this paragraph until the aggregate loss-cost data is reported. This fine is in addition to any fine imposed for the late reporting of data to the rating organization under paragraph (2).
- (4) No later than 95 days after the effective date of this section, the independent actuary shall complete and send the estimate of total loss-cost change to the commissioner, each rating organiza-

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tion, the Small Business Advocate, the President pro tempore of the Senate and the Speaker of the House of Representatives. The commissioner shall make the estimate available for public inspection.

- (5) No later than 25 days after the independent actuary completes and sends the report referred to in paragraph (4), each rating organization shall, pursuant to section 709(c) of the act, file new loss-cost changes which reflect the estimate of the sum total of loss-cost data compiled under this section. For failure to comply, the commissioner shall impose an administrative penalty of \$1,000 for every day that the loss-cost filing is not provided in accordance with this paragraph.
- (6) The commissioner shall give full consideration to the independent actuary's estimate from paragraph (4) in approving, disapproving or modifying the filing made under paragraph (5), pursuant to Article VII of the act. No later than 30 days after the approval of the filing, each new and renewal policy for workers' compensation shall reflect the new loss-cost filing of its rating organization.
- (7) The commissioner shall appoint and retain an independent actuary in accordance with this section until the independent actuary has prepared and sent the estimate as required by paragraph (4). The commissioner may appoint and retain an independent actuary after the estimate required by paragraph (4) has been completed and sent.
- (8) For the purpose of this section, an "independent actuary" means a member in good standing of the Casualty Actuarial Society or a member in good standing of the American Academy of Actuaries, who has been approved as qualified for signing casualty loss reserve opinions by the Casualty Practice Council of the American Academy of Actuaries and who is not an employee of the Commonwealth.

Sec 31 In a provision of the act not affected by this act, a reference to the word "referee" shall be deemed a reference to the phrase "workers' compensation judge."

Sec 31.1 Any reference in a statute to the Workmen's Compensation Appeal Board shall be deemed a reference to the Workers' Compensation Appeal Board.

Sec 31.2 Regulations of the Department of Health promulgated under section 306(f.2)(7) of the act shall be deemed regulations of the Department of Labor and Industry. The Legislative Reference Bureau shall recodify the regulations.

Sec 32 The provisions of this act are severable. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this act which can be given effect without the invalid provision or application.

Sec 32.1 (a) The amendment or addition of sections 204(a), 306(a.2) and (b)(2) and 309 of the act shall apply only to claims for injuries which are suffered on or after the effective date of this section.

(b) The addition of section 1402(a)(1) of the act shall not apply to the individual acting as director of adjudication on the effective date of this section.

Sec 32.2 The act of June 2, 1915 (P.L.762, No.340), referred to as the State Workmen's Insurance Fund Law, is repealed.

Sec 33 This act shall take effect as follows:

(1) The following provisions shall take effect immediately:

(i) The addition of section 306(a.2) of the act.

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- (ii) The addition of Article XV of the act.
 - (iii) Section 32.1 of this act.
 - (iv) Section 32.2 of this act.
 - (v) This section.
- (2) The remainder of this act shall take effect in 60 days.

[Editor's Note: Act 57 was approved June 24, 1996.]

The following provisions were enacted as part of Act 44 of 1993:

- Sec 23 The Commonwealth, its political subdivisions, their officials and employees acting within the scope of their duties shall enjoy and benefit from sovereign and official immunity from claims of subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits.
- Sec 25 (a) The following act and parts of acts are repealed to the extent specified:
- Section 654 of the act of May 17, 1921 (P.L. 682, No. 284), known as The Insurance Company Law of 1921, except with regard to insurance as to liability under the Longshore and Harbor Workers' Compensation Act (44 Stat. 1424, 23 U.S.C. §901 et seq.).
- 75 Pa.C.S. §§ 1735 and 1737, absolutely.
- (b) The provisions of 75 Pa.C.S. §§ 1720 and 1722 are repealed insofar as they relate to workers' compensation payments or other benefits under the Workers' Compensation Act.
- (c) All other acts and parts of acts are repealed insofar as they are inconsistent with this act.
- Sec 26 No changes in indemnity compensation payable by this act shall affect payments of indemnity compensation for injuries sustained prior to the effective date of this section.

[Editor's Note: Act 44 was approved July 2, 1993.]

The following provisions were enacted as part of Act 1 of 1995:

- Sec 3 This act shall apply as follows:
- (1) Except as provided in paragraph (2), the amendment or addition of sections 105.4, 105.5, 105.6 and 306(c)(8) of the act shall apply to claims filed on or after the effective date of this act.
 - (2) The amendment or addition of sections 105.5 and 306(c)(8)(I), (II) and (IV) shall apply retroactively to all claims existing as of the effective date of this act for which compensation has not been paid or awarded.
- Sec 4 This act shall take effect immediately.

[Editor's Note: Act 1 was approved February 22, 1995.]

APPENDIX B

ACCIDENTS REPORTED TO DEPARTMENT OF LABOR AND INDUSTRY

Act of 1913, P.L. 843, Amended 1937,
P.L. 56 (43 P.S. § 12-16)

AN ACT

Requiring employers to make report to the Department of Labor and Industry of accidents to employes, and prescribing a penalty, for non-compliance therewith.

- Sec 1 Within fifteen days after the date of any injury received by an employe in the course of or resulting from his employment, and within forty-eight hours of the death of an employe occurring from an injury received in the course of or resulting from his employment, the employer, whether a person, firm, or corporation, or the Commonwealth, or any political subdivision thereof, shall make report of such injury or death directly to the Department of Labor and Industry. Such report shall be made in such form as the Department of Labor and Industry shall prescribe, and shall set forth the name, address, and nature of the business of the employer; name, address, sex, age, nationality, wage or salary, and occupation of the employe; date, day of week, hour, place, cause, and character of the injury or death, and in the case of an injury, the nature of the injury, and the duration of the disability, or probable disability, as far as the same can be ascertained. Such employer shall, also, upon request of the Department of Labor and Industry, make such further report as may reasonably be required by it.
- Sec 2 Any person, firm, or corporation having knowledge of the occurrence of such personal injury or death to an employe, in the course of or resulting from his employment, who shall fail to make report as aforesaid, shall, upon conviction thereof in a summary proceeding, be sentenced to pay a fine of not more than one hundred dollars (\$100.00), or undergo imprisonment for not more than thirty (30) days, or both, at the discretion of the court.
- Sec 3 Reports made in accordance with this act shall not be evidence against the employer in any proceeding, either under the Workmen's Compensation Law of one thousand nine hundred and fifteen or otherwise.
- Sec 4 No employer who has made the report required by this act shall be required to make any other or further report of such injury or death to any other department of the government of the Commonwealth.
- Sec 5 This act shall not apply to casual employments; nor to injuries resulting in disability continuing less than the day shift or turn in which the injury was received.

APPENDIX C

Additional Relevant Statutory and Regulatory Provisions

- (1) Applicable Provisions of the Judiciary Act:
 - (a) Section 2(a)[995] of Act 1978, April 28, P.L. 202, No. 53, [42 P.S. § 20002(a)[995]], provides, in part:

“Whenever the Workmen’s Compensation Appeal Board shall grant a rehearing under section 426 of the act during the pendency of judicial review, the board shall file with the reviewing court a certified copy of its order granting such rehearing. A certified copy of any award or order of the board or of a referee sustained by the board, as affirmed or modified upon judicial review, may be filed with the office of the clerk of the court of common pleas of any county, and the proper officer shall enter judgment for the total amount stated by the award or order to be payable, whether then due and accrued or payable in future installments.”
 - (b) The provisions of this section [Section 426] are not deemed to be suspended or affected by the Rules of Appellate Procedure. See Pa.R.A.P., Rule 5102(b), 42 Pa.C.S.A.
- (2) Workers’ Compensation Security Fund Act, 77 P.S. §§ 1051-1065.1. (Formerly called “Insurance Company Law” in this volume.)
- (3) State Workmen’s Insurance Board (State Workmen’s Insurance Fund Enabling Statute), 77 P.S. §§ 201 et. seq.
- (4) Workers’ Compensation General Provisions, 34 Pa. Code § 121.
- (5) Workers’ Compensation Self-Insurance, 34 Pa. Code § 125.
- (6) Workers’ Compensation Medical Cost Containment, 34 Pa. Code § 127.
- (7) Workers’ Compensation Health and Safety, Pa. Bull., Vol. 25, No. 37, September 16, 1995, Statement of Policy, 34 Pa. Code § 143.
- (8) Section 2218 of the act of November 26, 1997 (P.L. 530, No. 57) provides:

Workers’ Compensation Assessment. — Effective July 1, 1998, the assessments for the maintenance of the Subsequent Injury Fund, the Workmen’s Compensation Supersedeas Fund and the Workmen’s Compensation Administration Fund under sections 306.2, 443 and 446 of the act of June 2, 1915 (P.L. 736, No. 338), known as the “Workers’ Compensation Act,” shall no longer be imposed on insurers but shall be imposed, collected and remitted through insurers in accordance with regulations promulgated by the Department of Labor and Industry.
- (9) Special Rules of Administrative Practice and Procedure before Referees, 34 Pa. Code § 131.
- (10) Special Rules of Administrative Practice and Procedure before the Workers’ Compensation Appeal Board, 34 Pa. Code § 111.

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LIBC-10	Authorization for Alternate Delivery of Compensation Payments
LIBC-14	Instructions for Religious Exception Application
LIBC-14A	Section 304.2 Application for Religious Exception of Specified Employes from the Provisions of the Pennsylvania Workers' Compensation Act
LIBC-14B	Employe's Affidavit and Waiver of Workers' Compensation Benefits and Statement of Religious Sect (to be filed with the §304.2 Application for Religious Exception)
LIBC-14C	Certification of Religious Exception
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LIBC-35	Answer to Petition for Commutation
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LIBC-337	Supplemental Agreement for Compensation for Disability or Permanent Injury
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STATEWIDE AVERAGE WEEKLY WAGE

The maximum weekly compensation payable is defined as the Statewide average weekly wage. See sections 105.1 and 105.2. The following schedule reflects the maximum weekly benefit:

May 1, 1972 through December 31, 1972	- \$141.00
January 1, 1973 through December 31, 1973	- \$150.00
January 1, 1974 through December 31, 1974	- \$159.00
January 1, 1975 through December 31, 1975	- \$171.00
January 1, 1976 through December 31, 1976	- \$187.00
January 1, 1977 through December 31, 1977	- \$199.00
January 1, 1978 through December 31, 1978	- \$213.00
January 1, 1979 through December 31, 1979	- \$227.00
January 1, 1980 through December 31, 1980	- \$242.00
January 1, 1981 through December 31, 1981	- \$262.00
January 1, 1982 through December 31, 1982	- \$284.00
January 1, 1983 through December 31, 1983	- \$306.00
January 1, 1984 through December 31, 1984	- \$320.00
January 1, 1985 through December 31, 1985	- \$336.00
January 1, 1986 through December 31, 1986	- \$347.00
January 1, 1987 through December 31, 1987	- \$361.00
January 1, 1988 through December 31, 1988	- \$377.00
January 1, 1989 through December 31, 1989	- \$399.00
January 1, 1990 through December 31, 1990	- \$419.00
January 1, 1991 through December 31, 1991	- \$436.00
January 1, 1992 through December 31, 1992	- \$455.00
January 1, 1993 through December 31, 1993	- \$475.00
January 1, 1994 through December 31, 1994	- \$493.00
January 1, 1995 through December 31, 1995	- \$509.00
January 1, 1996 through December 31, 1996	- \$527.00
January 1, 1997 through December 31, 1997	- \$542.00
January 1, 1998 through December 31, 1998	- \$561.00
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