

CHAPTER 69. MOTOR VEHICLE FINANCIAL RESPONSIBILITY LAW

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A.	AUTOMOBILE INSURANCE MEDICAL COST CONTAINMENT	69.1

Authority

The provisions of this Chapter 69 issued under section 28 of the act of February 7, 1990 (P. L. 11, No. 6), unless otherwise noted.

Source

The provisions of this Chapter 69 adopted November 29, 1991, effective November 30, 1991, 21 Pa.B. 5601, unless otherwise noted.

Subchapter A. AUTOMOBILE INSURANCE MEDICAL COST CONTAINMENT

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PRELIMINARY PROVISIONS**§ 69.1. Purpose.**

This chapter implements section 18 of Act 6 relating to insurer payments for medical treatment provided to injured persons covered by automobile insurance policies.

§ 69.2. Applicability.

This chapter applies to medical payments made by insurers under automobile insurance policies issued under the MVFRL. This chapter applies to insurer payments to providers for services rendered on and after November 30, 1991.

§ 69.3. Definitions.

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

Act 6—The act of February 7, 1990 (P. L. 11, No. 6).

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

Care or services—The treatment, accommodations, products or services provided by a person or institution.

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

Commissioner—The Insurance Commissioner of the Commonwealth.

DRG—Diagnostic-related group.

Department—The Insurance Department of the Commonwealth.

HCFA—The Health Care Financing Administration.

Insured—An injured person covered by an automobile insurance policy issued under the MVFRL.

Insurer—A property and casualty insurance company providing coverage under automobile insurance policies to residents of this Commonwealth.

Intermediary—An organization with a contractual relationship with HCFA to process Medicare Part A claims.

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

MVFRL—Motor Vehicle Financial Responsibility Law—Title 75 of the *Pennsylvania Consolidated Statutes* §§ 1701—1799.7 (relating to the Motor Vehicle Financial Responsibility Law).

Medicare Part A—Medicare hospital insurance benefits which reimburse providers for facility-based care, such as in-patient and out-patient hospital services and skilled nursing care.

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

Medicare payment—Payment at 110% of the Medicare reimbursement allowance which includes the prevailing charge at the 75th percentile; the applicable fee schedule, the recommended fee or the inflation index charge; the DRG payment; or any other Medicare reimbursement mechanism; as applied in this Commonwealth under the Medicare Program.

Medicare prevailing charge—The lowest customary charge high enough to include 75% of the individual provider charges for services as adjusted by all limitations mandated by HCFA and the carrier.

Medicare recommended fee—The fee for which a Medicare payment schedule does not exist, and which is developed based upon a solicited recommendation from a consulting specialist or group of specialists. This fee may vary depending upon the specifics of a particular case.

PRO—Peer Review Organization—A professional organization with which HCFA or the Commonwealth contracts for medical review of Medicare or Medical Assistance services, or a health care entity approved by the Commissioner, that engages in reviewing medical files for the purpose of determining that medical and rehabilitation services are medically necessary and economically provided.

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

Provider—A person or institution which provides treatment, accommodations, products or services.

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

Urgent injury—The term 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—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.

Notes of Decisions

Usual and Customary Charge

The definition of "usual and customary charge" establishes the reimbursement level for the single provider based on an aggregate of charges for similarly situated providers and is not inconsistent with 75 Pa.C.S. § 1797. *Hospital Association of Pennsylvania, Inc. v. Foster*, 629 A.2d 1055 (Pa. Cmwlth. 1993).

The definition of "usual and customary charge" does not conflict with the meaning of the legislature's language and the common usage of 2 terms under the Medicare Program. *Hospital Association of Pennsylvania, Inc. v. Foster*, 629 A.2d 1055 (Pa. Cmwlth. 1993).

COVERED SERVICES

§ 69.11. Payment limitation applicability.

(a) The payment limitations of Act 6 apply to a provider rendering services to an injured person whose medical costs are covered by automobile insurance issued under the MVFRL. The payment limitations of Act 6 also apply to providers not currently participating in Medicare.

(b) The payment limitations of Act 6 apply in cases when care is rendered by a Pennsylvania licensed provider to a Pennsylvania resident covered by automobile insurance for injuries arising out of the maintenance or use of a motor vehicle, irrespective of where the injuries occurred or where the care is rendered.

§ 69.12. Exemption from payment limitations.

(a) Acute care treatment and services for life-threatening or urgent injuries, and services for burn injury patients rendered by providers during transport to and while at a trauma center or a burn facility, shall be paid at the usual and customary charge when the insured's condition meets the definition of urgent or life-threatening injury, based upon information available at the time of the insured's assessment. When the initial assessment at the trauma center determines that the insured's injuries are not urgent or life-threatening, the exemption shall apply only to the initial assessment and the transportation to the facility. A decision by ambulance personnel that an injury is urgent or lifethreatening shall be presumptive of the reasonableness and necessity of the transport to a trauma center or burn facility unless there is clear evidence of a violation of the American College of Surgeons' Triage Guidelines.

(b) A provider may seek a determination that a Medicare reimbursement allowance under the Medicare Program is unreasonable by applying to the

Department for a deviation from the Medicare reimbursement allowance. The application shall be provider specific and shall be for the specific Medicare reimbursement allowance that is believed to be unreasonable. The application for a different Medicare reimbursement allowance will be subject to a formal adjudicatory hearing in accordance with 2 Pa.C.S. §§ 501—508 and 701—704 (relating to the Administrative Agency Law).

Cross References

This section cited in 31 Pa. Code § 69.42 (relating to payments under the act); and 31 Pa. Code § 69.43 (relating to insurer payment requirements).

PROVIDER BILLING

§ 69.21. Allowable payment amounts.

The provider may not require payment in excess of the Medicare payment pertaining to the applicable specialty under Medicare for comparable services at the time services were rendered, or the provider's usual and customary charge, whichever is less. An insurer shall use the Medicare payment applicable in this Commonwealth to determine the appropriate payment. The applicable Medicare payment shall be utilized even when a service is not a reimbursed service under Medicare. If no Medicare payment has been calculated, payment shall be 80% of the provider's usual and customary charge.

§ 69.22. Billing procedures.

(a) An insurer shall apply the Medicare payment limitations of Act 6 to provider services covered by bodily injury liability, uninsured and underinsured motorists, first-party medical and extraordinary medical benefits coverages under an automobile insurance policy.

(b) In an action for damages against a tortfeasor arising out of the maintenance or use of a motor vehicle 75 Pa.C.S. § 1720 (relating to subrogation) applies.

(c) If an insured's first-party limits have been exhausted, the insurer shall, within 30 days of the receipt of the provider's bill, provide notice to the provider and the insured that the first-party limits have been exhausted.

(d) Upon receipt of a provider's bill, the insurer shall make a determination of the appropriate Medicare payment and pay up to the first-party benefit limits of the policy. If the determined amount exceeds the benefit limits of the policy, or the determined amount plus previously paid benefits exceed the benefit limits of the policy, the provider may directly bill the insured or a secondary insurance carrier.

(e) If only a portion of the provider's services are paid by the automobile insurance policy, because benefit limits have been exhausted, the provider may bill the insured for the remaining services not paid under the automobile insurance policy. The provider's bill to the insured shall be limited to the remaining services not paid under the automobile insurance policy.

Example: Assume an insured has \$5,000 of first-party benefits from the insured's automobile insurance policy and no health insurance. Further assume the provider's bill totals \$10,000 and the Medicare payment for the \$10,000 total bill would be \$6,000. The actual worth of the \$5,000 of first-party benefits applied at the appropriate Medicare payment is \$8,333 worth of services of the \$10,000 bill (\$5,000 is to \$6,000 as x is to \$10,000; x is \$8,333). The provider may bill the insured \$1,677, or \$10,000 less \$8,333, for the remaining services not paid under the automobile insurance policy.

(f) If another insurance policy exists and a provider bills that insurer for the actual worth of remaining services not paid (such as \$1,667 in the Example in subsection (e)) that insurer shall determine the appropriate amount of payment to the provider under the terms of the insured's health or other insurance policy, without regard to the medical cost containment provisions of the act.

(g) When multiple providers seek reimbursement and when their bills for services collectively exceed the policy limits, providers shall be paid by the insurer in the order the insurer receives a provider's bill. If bills are received simultaneously, the bill with the lowest payment amount in accordance with § 69.43 (relating to insurer payment requirements) shall be paid first.

(h) If no portion of the provider's bill is payable under automobile insurance coverage, the Medicare payment limitations no longer apply. A provider may directly bill the insured or other insurance carrier as it has prior to passage of Act 6.

Notes of Decisions

Cost Containment

This regulation does not prohibit the application of the cost containment provisions to a medical bill remaining after an injured party's first party benefits have dissipated and where the party is seeking recovery from a third party tortfeasor's liability insurance. *Pittsburgh Neurosurgery Associates, Inc. v. Danner*, 733 A.2d 1279 (Pa. Super. 1999); appeal denied 751 A.2d 192 (Pa. 2000).

Due Process

This section is rationally related to the statutory purpose of regulating and reducing the cost of automobile insurance and does not violate the substantive due process rights of physicians. *Pennsylvania Medical Society v. Foster*, 624 A.2d 274 (Pa. Cmwlth. 1993).

Regulations, which permit medical providers to bill insured parties directly for services not paid by their insurer for reason that the insured's policy limits have been exhausted, cure any alleged unconstitutional vagueness in statute. Because either the insurer, a provider or the insured may appeal a private, nongovernmental peer review organization's (PRO) determination to court, the process by which permissible charges by a provider are limited does not violate due process. *Pennsylvania Medical Providers Association v. Foster*, 613 A.2d. 51 (Pa. Cmwlth. 1992).

§ 69.23. Applicable Medicare payment and codes.

(a) 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. If a Medicare code exists for application to a specific provider specialty, that code shall be used.

(b) Medicare payments are updated periodically by HCFA and the carrier and intermediaries. Insurers and providers shall utilize the latest Medicare payments as updated and provided by HCFA. Medicare payments shall be utilized by insurers and providers within 30 days of their effective date or date of official publication by HCFA, whichever occurs later.

(c) Medicare procedure codes are updated periodically by HCFA and the carrier and intermediaries. The updated Medicare procedure codes shall be utilized by insurers and providers within 30 days of their effective date or date of official publication by HCFA, whichever occurs later.

§ 69.24. Unbundling.

A provider may not fragment or unbundle charges imposed for specific care except as consistent with the Medicare Program. Changes to a provider's codes by an insurer shall be made only as consistent with the Medicare Program and when the insurer has sufficient information to make the changes and following consultation with the provider. An insurer shall substantiate the reasons for coding changes to the provider in writing.

§ 69.25. Required billing information.

(a) In submitting a request for payment to an insurer, a provider may state the full charge for services rendered. To the extent possible, a Part A provider shall submit DRG payment information including estimated pass-throughs and outliers as calculated by the intermediary and shall utilize Form UB82 or the form currently in use by Medicare. If Form UB82 is used, the intermediary assigned provider number shall be shown on the form. To the extent possible, a Part B provider shall utilize Medicare procedure codes for the service rendered and shall utilize Form HCFA-1500 or the form currently in use by Medicare. Provider specialty codes shall be provided, if known. Failure to use Forms UB82 and HCFA-1500 or Medicare procedure codes does not preclude payment by an insurer if the provider submits a complete narrative describing the services rendered for which payment is requested, including complete information on the insured and provider. When applicable, complete information on the primary or secondary diagnosis shall also be submitted.

(b) Insurer processing of provider bills under this section is subject to the Unfair Insurance Practices Act (40 P. S. §§ 1171.1—1171.15).

§ 69.26. Complaint submissions to the Department by providers.

(a) Before submitting a complaint to the Department, a provider shall first attempt to resolve the complaint in writing with the affected insurer and show evidence that the attempt at resolution failed. An insurer shall respond to complaint correspondence from a provider within 30 days of receipt.

(b) In submitting an unresolved complaint to the Department, a provider shall include the following information for each insured person:

- (1) The name of the insured.
- (2) The name of the provider.
- (3) The name of the insurer.
- (c) The following documentation shall be attached:
 - (1) A copy of the claim filed with the insurer.
 - (2) A copy of the explanation of benefits paid or denied by the insurer.
 - (3) A copy of the provider's complaint correspondence sent to the insurer.
 - (4) A copy of the insurer's response to the provider's complaint.
 - (5) A written explanation of why the provider disagrees with the insurer's decision.
 - (6) The name, address and telephone number of the insurer's representative answering the provider's complaint.
 - (7) The name and telephone number of a contact person in the provider's office.
- (d) Questions or disputes regarding whether care conforms to professional standards of performance and is medically necessary shall be resolved in accordance with the peer review provisions of Act 6 and this chapter.
- (e) The submission of a complaint to the Department will not alter the provider's obligation to adhere to the 30-day time line for requesting a reconsideration of a PRO determination.
- (f) This section does not limit or restrict any person with an interest in a medical claim payment from making a complaint to the Department or another governmental unit having jurisdiction over any party to a medical claim.

Notes of Decisions

Regulation that provides the process and procedures for a health care provider to submit a complaint to the Department of Insurance did not create an administrative remedy that had to be exhausted before provider could bring a private cause of action for interest on late payments from insurance companies. *Schappel v. Motorists Mutual Insurance Company*, 934 A.2d 1184, 1189—1190 (Pa. 2007)

INSURER CLAIMS PROCESSING

§ 69.41. Medicare data.

An insurer may obtain data on Medicare procedure codes and Medicare payments from the carrier and intermediaries at a cost for preparation and distribution of the data. A request for services beyond providing this data from the carrier and intermediaries is a matter of private negotiation.

§ 69.42. Payments under the act.

An insurer shall make payments to providers in accordance with the Medicare Program as applied in this Commonwealth by the carrier and intermediaries. Care covered under the Medicare Program shall be reimbursed at 110% of the Medicare payment or a different allowance as may be determined under § 69.12(b) (relating to exemption from payment limitations). Medicare co-insurance and deductibles may not be excluded in payments made by the insurer.

§ 69.43. Insurer payment requirements.

(a) For Part A providers, the payment shall be 110% of the Medicare reimbursement allowance plus, when applicable, the estimated pass-through costs and applicable cost or day outliers which are facility specific as calculated by the intermediaries. An insurer is not required to maintain an open claim file until final settlement of the pass-through costs and outliers. A claim file may be closed upon payment of the estimated pass-through costs and outliers. The estimated pass-through costs should be submitted by the provider at the time of billing. Neither a provider nor an insurer may seek to reopen closed claims or bill upon final settlement of the pass-through costs and outliers. A provider may seek payment for these amounts if an insurer has not paid for the estimated pass-through costs and outliers.

(b) If a Medicare fee schedule exists for out-patient, rehabilitation and physician services, insurers shall pay Part A and B providers at 110%. If the Medicare reimbursement allowance is the Medicare aggregate payment, in areas such as out-patient services, rehabilitation services, and home health care services, payment shall be 110% of the actual cost based upon the cost-to-charge ratios for each ancillary, out-patient, or other reimbursable cost center service utilized by the insured. When an ancillary cost center's services consist of a combined fee schedule and a blended payment, insurers shall pay 110% of the fee schedule amount plus 110% of the actual cost based upon the cost-to-charge ratio payment for the ancillary cost center. Payment for in-patient rehabilitation services shall consist of the routine cost per diem (room and board) plus the actual cost based upon the cost-to-charge ratio of each ancillary cost center service times 110%. Payment for out-patient rehabilitation services shall be the actual cost based upon the cost-to-charge ratio for each ancillary cost center service times 110%. The costs used to develop these payments shall be based upon the latest audited Medicare cost report for that facility.

(c) An insurer shall pay the provider's usual and customary charge for services rendered when the charge is less than 110% of the Medicare payment or a different allowance as may be determined under § 69.12(b) (relating to exemption from payment limitations). An insurer shall pay 80% of the provider's usual and customary charge for services rendered if no Medicare payment exists. In calculating the usual and customary charge, an insurer may utilize the requested payment amount on the provider's bill for services or the data collected by the carrier or intermediaries to the extent that the data is made available.

(d) An insurer shall provide a complete explanation of the calculations made in computing its determination of the amount payable including whether the calculation is based on 110% of the Medicare payment, 80% of the usual and customary charge or at a different allowance determined by the Commissioner under § 69.12(b). A bill submitted by the provider delineating the services rendered and the information from which a determination could be made by the insurer as to the appropriate payment amount will not be construed as a demand for payment in excess of the permissible payment amount.

Notes of Decisions*Amendment*

Denial of payment of insured's medical bills for treatment rendered subsequent to act's amendment by which the peer review procedure was adopted was proper where insured's policy, accident and some treatment all preceded the amendment. *Frey v. State Farm Mutual Auto Insurance Co.*, 632 A.2d 930 (Pa. Super. 1993).

Calculation of Payment

In an action by a provider of outpatient rehabilitation services seeking payments for medical services, the insurer was required to reimburse the provider for the difference between the provider's charges calculated at 110% of the actual cost based upon the cost-to-charge ratio and the amount the provider incorrectly originally billed, which was 80% of the usual and customary charge, where the original payments made by the insurer were not authorized under the law. *Med/Aid, Inc. v. State Farm Insurance Co.*, 38 D. & C. 4th 41 (1997).

Jurisdiction

The court had jurisdiction to conduct a pre-enforcement review of this section since the administrative remedy was unavailable or inadequate and the effect on the party seeking review was direct and immediate. *Pennsylvania Association of Rehabilitation Facilities v. Foster*, 608 A.2d 613 (Pa. Cmwlth. 1992).

Cross References

This section cited in 31 Pa. Code § 69.22 (relating to billing procedures).

PEER REVIEW**§ 69.51. Authority.**

A PRO has the authority to evaluate the reasonableness and medical necessity of care, and the professional standards of performance including the appropriateness of the setting where the care is rendered, and the appropriateness of the delivery of the care rendered.

Cross References

This section cited in 31 Pa. Code § 69.55 (relating to criteria for Department approval of a PRO).

§ 69.52. Peer review procedures.

(a) A provider's bill shall be referred to a PRO only when circumstances or conditions relating to medical and rehabilitative services provided cause a prudent person, familiar with PRO procedures, standards and practices, to believe it necessary that a PRO determine the reasonableness and necessity of care, the appropriateness of the setting where the care is rendered, and the appropriateness of the delivery of the care. An insurer shall notify a provider, in writing, when referring bills for PRO review at the time of the referral.

(b) An insurer shall make a referral to a PRO within 90 days of the insurer's receipt of sufficient documentation supporting the bill. An insurer shall pay bills for care that are not referred to a PRO within 30 days after the insurer receives sufficient documentation supporting the bill. If an insurer makes its referral after the 30th day and on or before the 90th day, the provider's bill for care shall be paid.

(c) During an initial determination, a PRO shall request in writing from the provider the records and documents necessary to undertake its review. The PRO shall afford the provider an opportunity to discuss the case with the reviewer and to submit information to the reviewer prior to a final determination.

(d) A PRO's initial determination shall be completed within 30 days after the receipt of requested information. When a provider fails to respond to the PRO's inquiry or provide requested information, a PRO may commence its review 30 days after the request for information is postmarked. If additional information critical for the outcome of the determination is submitted by a provider or requested by a PRO, the 30-day review period may be tolled up to 20 days for the information to be received and taken into consideration.

(e) A PRO shall provide a written analysis, including specific reasons for its decision, to insurers, which shall within 5 days of receipt, provide copies to providers and insureds. Without the written analysis, the review may not be considered an initial determination and unpaid provider bills subject to the review shall be paid by the insurer. An insurer may request another initial determination if the request is made within 90 days of its receipt of the bill and supporting documentation in accordance with subsection (b). The written analysis of the initial determination shall notify all parties that they have 30 days from the day the initial determination is effected to request a reconsideration and the process and location for filing a request for reconsideration.

(f) A PRO's initial determination resulting in the denial of a provider's claim, in whole or in part, shall be effected by a licensed practitioner of like speciality or a licensed practitioner with experience providing and prescribing the care subject to the review.

(g) Absent a change of condition, a decision of not medically necessary by the PRO is basis for an insurer to deny payment for similar services to the same insured resulting from the same accident. The insured or subsequent provider has the right to request a reconsideration of the initial determination for subsequent treatment or services received or provided.

(h) An insurer, provider or insured may request, in writing, reconsideration of the initial PRO determination within 30 days from the date the initial determination is effected. A PRO may set a reasonable charge for a reconsideration but the charge for a reconsideration may not exceed the charge for the initial review. An insurer shall make full payment of the charge for reconsideration to the PRO, but the amount paid for the reconsideration shall be ultimately borne by the party against whom a reconsideration determination is made.

(i) A reconsideration shall be effected by a licensed practitioner of like speciality as the provider subject to the reconsideration review. The licensed practitioner effecting the reconsideration review may not be the same licensed practitioner who rendered the PRO's initial determination.

(j) A PRO shall afford the party requesting reconsideration an opportunity to discuss the case with the reviewer and to submit additional information identified by the reviewer before making a final determination of the reconsideration.

(k) A reconsideration shall be based upon the information that led to the initial determination, new information found in medical records or additional evidence submitted by the requesting party.

(l) A PRO shall complete a reconsideration within 30 days after receipt of the information submitted under subsection (k). If additional information critical for the outcome of the determination is submitted by a provider or requested by a PRO, the 30-day review period may be tolled up to 20 days for the information to be received and taken into consideration. A PRO shall send written notification of the reconsideration determination to the insurer, which shall within 5 days of receipt provide copies to providers and insureds. The written notice shall contain the basis and rationale for the reconsideration determination.

(m) Upon determination of a reconsideration by a PRO, an insurer, provider or insured may appeal the determination to the courts.

(n) The insured may not be billed during the peer review process.

Cross References

This section cited in 31 Pa. Code § 69.54 (relating to PRO reporting responsibility); and 31 Pa. Code § 69.55 (relating to criteria for Department approval of a PRO).

Notes of Decisions

Constitutionality

Regulations, which permit medical providers to bill insured parties directly for services not paid by their insurer for reason that the insured's policy limits have been exhausted, cure any alleged unconstitutional vagueness in statute. Because either the insurer, a provider or the insured may appeal a private nongovernmental peer review organization's (PRO) determination to court, the process by which permissible charges by a provider are limited does not violate due process. *Pennsylvania Medical Providers Association v. Foster*, 613 A.2d 51 (Pa. Cmwlth. 1992).

Erroneous Regulation

Insured is not required to seek reconsideration of adverse peer review decision under motor vehicle financial responsibility law before initiating action in common pleas court to recover medical benefits under automobile insurance policy. *Terminato v. Pennsylvania National Insurance Company*, 645 A.2d 1287, 1288 (Pa. 1994); *Kuropatwa v. State Farm Insurance Company*, 721 A.2d 1067, 1071 (Pa. 1998).

§ 69.53. PRO standards for operation.

(a) A PRO shall contract, in writing, jointly or separately with an insurer for the provision of peer review services as authorized by Act 6 and this chapter.

(b) A PRO may not mediate disputes over appropriate charges, costs or payments, and may not engage in administration of claims for insurers. A PRO engaging in claims administration shall establish a separate company to perform peer review services.

(c) A PRO shall reimburse providers the cost for copying of records at the current rate HCFA reimburses its contracted PRO.

(d) Written notice of determinations shall be mailed to the insurer within 3 working days of conclusion of a PRO's review.

(e) A PRO shall apply National, or when appropriate, regional norms in conducting determinations. If National and regional norms do not exist, a PRO shall establish written criteria to be used in conducting its reviews based upon typical patterns of practice in the PRO's geographic area of operation.

(f) A PRO shall maintain reasonable security and confidentiality practices to prevent unauthorized access to PRO records and information including training of employees in procedures to protect the confidentiality of information.

Cross References

This section cited in 31 Pa. Code § 69.55 (relating to criteria for Department approval of a PRO).

§ 69.54. PRO reporting responsibility.

(a) A PRO shall submit an annual report to the Commissioner. The report shall include, at a minimum:

- (1) The number of determinations performed.
- (2) The results of initial determinations delineated by the provider and insurer.
- (3) The number of reconsiderations requested.
- (4) The number of initial determinations overturned.
- (5) The number of determinations where the review period was tolled under § 69.52(d) and (l) (relating to peer review procedures).

(b) A PRO shall file this report with the Commissioner by March 1 of each year with the information for the preceding calendar year.

(c) The initial annual report is due by March 1, 1992 and shall cover the period from June 1, 1990 through December 31, 1991.

Cross References

This section cited in 31 Pa. Code § 69.55 (relating to criteria for Department approval of a PRO).

§ 69.55. Criteria for Department approval of a PRO.

(a) A PRO shall apply in writing to the Commissioner for approval to contract with an insurer to provide peer review services in accordance with the act and this chapter. If the application is disapproved, the PRO may appeal the disapproval to the Commissioner. If the Commissioner determines that reasonable grounds exist to review the disapproval, the Commissioner may schedule a hearing to review the determination. The hearing shall be conducted in accordance with 2 Pa.C.S. §§ 501—508 and 701—704 (relating to the Administrative Agency Law).

(b) A PRO applicant shall include in its written application the following information:

- (1) A Certification of Independence. A PRO may not be owned by a Pennsylvania-licensed insurer. While a PRO may be organized by one or more insurers, that PRO may not review the claims of those insurers, may not be a subsidiary or affiliate of those insurers' corporate structure and none of the PRO's officers or directors may have a direct financial interest in the insurers.

PRO personnel may not review services provided to an insured by an institution or agency in which they have financial interest.

(2) A description of previous experience as a PRO and the length of time in operation.

(3) A certification that reviews are conducted by medical personnel licensed in this Commonwealth.

(4) A compensation policy. A PRO shall charge for its service on a flat fee or hourly rate basis. A PRO may not charge for services on a percentage or contingency fee basis.

(5) A quality assessment of the PRO's review services, including examples of the PRO's review procedures.

(6) A policy statement on the preservation of the confidentiality of medical records.

(7) A certification that the PRO will operate and provide services in accordance with §§ 69.51—69.54 and this section.

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