WORKERS' COMPENSATION

HEALTH CARE PAYMENT SYSTEM FAQS

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Why do some codes have fees set for them and others don't? What does POC mean?

"POC" means "percent of actual charge." For instance, 68 POC means that fee is paid at 68% of the actual charge.

Effective January 31, 2015, and excluding those exceptions mandated in the Workers' Compensation Act plus CPT Code 99080 (used for the physicians form), the fee schedules were populated with actual fee dollar amounts based on relative value units from the Centers for Medicare and Medicaid Services (CMS) and conversion factors calculated from Delaware workers' compensation data. Whenever one of two elements – 1) a CMS relative value or alternative relative value source; and 2) enough data to calculate a conversion factor – used in the calculation does not exist, then the paid amount for that health care treatment or service is determined using a percent of charge that reflects the 2015 reduction mandated in 19 Del. C. §2322B. The percentages of charge for health care treatment or services not itemized in the fee schedules are as follows:

- → Professional services, HCPCS – 53.7 POC
- → Laboratory and pathology – 53.7 POC
- → Radiology – 53.7 POC
- → Dental services – 53.7 POC
- → Independently operated diagnostic testing facility – 53.7 POC
- → Hospital outpatient – 47.4 POC
- → Ambulatory surgery centers – 50.6 POC for geozip 197/198 and 52.5 POC for geozip 199

What is a geozip?

Pursuant to 19 DE Admin Code 1341, Section 2.0, "Geozip" means the geographical area used to determine the "Delaware specific geographically adjusted factor" mandated in 19 Del.C. §2322B(3).

What is a modifier?

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. If more than one modifier is needed, place modifier 99 after the procedure code to indicate that two or more modifiers will follow. Some modifier descriptions in this fee schedule have been changed from the CPT language.

Where can I find the Correct Coding Policy Manual?

The OWC adopted the National Correct Coding Initiative as the review standard for bundling edits, pursuant to 19 DE Admin Code 1341, Section 4.1.5.

Where can I find the Payment Guide to Global Days?

You may find follow-up days (FUDS) listed as a column in the itemized fee schedule. In addition, 19 DE Admin Code 1341, Section 4.1.5 cites the source used.

How and when are the fees adjusted each year? Where can I find the indicators used to adjust the fees - Consumer Price Index -- Urban, U.S. City Average, All Items, as published by the United States Bureau of Labor Statistics (the professional services fee schedule) ,as well as the Consumer Price Index-Urban, U.S. City Average, Medical (ASCs and Hospitals)?

GENERAL INFORMATION

House Bill 373, signed into law on July 15, 2014, mandated the Workers' Compensation Oversight Panel (Panel) to create a fee schedule based on the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) relative values. The regulations promulgated to support HB373 provide the frame work for the new fee schedules (professional services; ambulatory surgery centers, hospital outpatient facilities and hospital inpatient facilities) are available here.

Pursuant to 19 Del. C. §2322B(5), "the payment system will be adjusted yearly based on percentage changes to the Consumer Price Index-Urban, U.S. City Average, All Items, as published by the United States Bureau of Labor Statistics. Notwithstanding the annual CPI-Urban increase permitted by this paragraph, no individual procedure in Delaware paid for through the workers' compensation system (as identified by HCPCS level 1 or level 2 code) shall be reimbursed at a rate greater than 200% of that reimbursed by the federal Medicare system, provided that radiology services may be reimbursed at up to 250% of the federal Medicare reimbursement and surgery services may be reimbursed at up to 300% of the federal Medicare reimbursement."

ANESTHESIA METHODOLOGY

Anesthesia is paid pursuant to 19 DE Admin Code 1341, Section 4.20, which can be read here. Use CMS base units, which are available to download here.

Effective January 31, 2026, the Conversion Factor to be used for geozip 197-198, is $84.77 (eighty four dollars seventy seven cents) per unit and for geozip 199, it is $64.43 (sixty four dollars forty-three cents) per unit.

PHARMACY

Pharmacy is paid pursuant to 19 DE Admin Code 1341, Section 4.14, which you may find HERE. The pharmacy fee schedule calculations are as follows: the Average Wholesale (AWP) for the National Drug Code (NDC) for the prescription drug or medicine on the day it was dispensed minus thirty one point nine percent (31.9%) plus a

dispensing fee of three dollars twenty-nine cents ($3.29) for brand name drugs or medicines, or minus thirty-eight percent (38.0%) plus a dispensing fee of four dollars ten cents ($4.10) for generic drugs or medicines. These revisions were put into place in the revised fee schedule effective 01/31/2018.

REVENUE NEUTRAL INSTRUCTIONS

Pursuant to 19 DE Admin Code 1341, Section 4.4.3 "The Department of Labor will publish to its web site additional special instructions associated with the revenue neutral fee conversion, where applicable."

CONVERSION FACTORS FOR FACILITIES

19 DE Admin Code 1341, Section 4.7, which you may find (HERE) will contain the methodology used to create the ambulatory surgery center, hospital outpatient, and hospital inpatient itemized fee schedules. Although you must use the fees in the schedules provided at dowc.refmed.com/download.asp, the regulation also requires the Department of labor to publish on its web site "an appropriately calculated conversion factor" for these facilities. The conversion factors for each geozip are as follows:

AMBULATORY SURGERY CENTERS

- Geozip 197, $180.901, conversion factor
- Geozip 199, $162.656, conversion factor

HOSPITAL OUTPATIENT

- Geozip 197, $211.610, conversion factor
- Geozip 199, $238.806, conversion factor

HOSPITAL INPATIENT

- Geozip 197, $10,988.033, conversion factor
- Geozip 199, $13,316.411, conversion factor

SPECIALTY HOSPITALS, SUCH AS REHABILITATION HOSPITALS

19 DE Admin Code 1341, Section 4.10.5, which you may find (HERE), will contain the methodology for calculating these fees and says the Department of Labor will publish to its web site, "the average percentage of acute care hospitals above Medicare," which is a value needed for the calculation. That number for each geozip is as follows:

- Geozip 197, the percentage to Medicare is 145.2%
- Geozip 199, the percentage to Medicare is 185.5%

STATUS INDICATOR Q3 AND ADDENDUM M

19 DE Admin Code 1341, Section 4.23.5, Status Indicator Q3, mentions Addendum M, which may be found on the Centers for Medicare and Medicaid Services web site at cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS1204971.html.

Please note, you will find fees in the fee schedules for CPT/HCPCS codes that have Status Indicator Q3 because those codes are not always bundled.

How are HCPCS codes reimbursed?

Users can find HCPCS reimbursement amounts in the fee schedule.

Did the OWC adopt the new MS-DRGs?

Yes. The MS-DRGs have been adopted with the current state conversion factors.

Does the fee schedule apply to medical treatments before May 23, 2008?

No. The schedule only applies to treatments covered under the Act and provided on or after May 23, 2008. The date of injury is not relevant.

Are emergency services exempt from the HCPS and fee schedule?

Emergency services, are paid pursuant to 19 Del. C. §2322B(3).

Does the Delaware fee schedule address missed appointments?

No. The fee schedule only applies to services actually rendered in the treatment of an injured worker.

Should we pay medical bills according to our contract or the fee schedule?

Pursuant to Title 19 Del.C. §2322B(6), "If an employer or insurance carrier contracts with a provider for the purpose of providing services under this chapter, the rate negotiated in any such contract shall prevail."

How do I reimburse for an out-of-state treatment?

Pursuant to Title 19 Del.C. §2322B(7), "The health care payment system shall include provisions for health care treatment and procedures performed outside of the State of Delaware. If any procedure, treatment or service is rendered by a health care provider, hospital or ambulatory surgery center, who is licensed or permitted to render such procedure, treatment or service within the State of Delaware, but performs such procedure, treatment or service outside of the State of Delaware, the amount of reimbursement shall be the amount as set forth in the health

care payment system. In the event that a procedure, treatment or service is rendered outside the State of Delaware by a health care provider, hospital or ambulatory surgery center, not licensed or permitted to render such procedure, treatment or service within the State of Delaware but licensed in another state, the amount of reimbursement shall be the lesser of:

- → The health care provider's usual and customary fee;
- → The maximum allowable fee pursuant to the Delaware workers' compensation health care payment system adopted pursuant to this section;
- → The maximum allowable fee pursuant to any workers' compensation health care payment system in the state in which the services at issue were rendered; or
- → If an employer or insurance carrier contracts with a provider for the purpose of providing services under this chapter, the rate negotiated to any such contract.

How do you reimburse for the pharmaceutical drugs and/or drugs listed on the OWC Preferred Drug List?

Effective 9/11/13, significant revisions occurred in the pharmacy fee regulations to support the statutory changes mandated in HB175. Pursuant to 19 DE Admin Code 1341, Section 4.14 (CLICK HERE) , the revised pharmacy regulation includes a new percent of AWP applied to the specified drug pricing indices; guidelines for physicians dispensing from their office; caps on fees for compounded and repackaged drugs; a new drug formulary, as well as a "Justification for Use of Non-Preferred Medication" form to obtain prior authorization for drugs identified as non-preferred; and protocols for prescribing
brand name prescriptions.

Click on the link above to access the current regulations. The left side menu of the web page includes links to the new drug formulary and the justification form (click on "Forms").

Medications that do not fall within the categories listed in the new drug formulary should be prescribed and dispensed in their generic form, pursuant to the caveats described in Section 4.14 and per the workers' compensation health care practice guidelines.

Effective 2/11/2014, Medi-Span became the sole source provider for pharmacy AWP. We are unable to publish the AWP reimbursement rates on this website. We suggest obtaining the AWP info from your insurance carriers or providers. The Medi-Span Master Drug Data Base (MDDB) or Drug Topics database is also available for purchase via the Medi-Span website.

What is the percentage reduction set by the Workers' Compensation Oversight Panel and the dispensing fee for pharmaceutical drugs?

For the fee scheduled effective January 31, 2018, the percentage reduction set by the WCOP is 31.9% for brand name drugs or medicines and 38.0% for generic drugs or medicines. The dispensing fee for brand name drugs is $3.29 and for generic drugs it is $4.10.

Is balance billing allowed?

No. Pursuant to Title 19 Del. C. §2322F(l)(1), "Any health care provider rendering services under this chapter shall be prohibited from billing or invoicing an employee, employer or insurance carrier for charges or expenses other than those authorized by this chapter and the health care payment system provided for herein. No health care provider rendering treatment or services under this chapter shall seek payment for charges from an employee except as authorized by this section."

How do I pay bills where there are professional and technical components (PC/TC)?

Fees for total, professional, and/or technical reimbursement components may appear in the Professional Services fee schedule in the areas of surgery, radiology, pathology and laboratory, and medicine.

- → When you receive a bill from a healthcare provider with no modifier, you can assume that the charge is for the total component, and pay the fee schedule amount for the "total component." If POC68 appears, pay 68% of the charged amount.
- → When you receive a bill with the modifier "PC" or "26," the charge is for the professional component and is paid at the amount listed for the "professional component." If POC68 appears, pay 68% of the charged amount.
- → When you receive a bill with the modifier "TC," this indicates the charge is for the technical component of the service and is paid at the amount listed for the "technical component." If POC68 appears, pay 68% of the charged amount.
- → When combined, the TC/PC splits should equal the fee schedule (actual number or 68POC, whichever is appropriate) for the total component.

Should a medical provider send bills to the employer or the payer?

Send bills to the employer (if not insured) or insurance carrier.

Pursuant to Title 19 Del.C. §2322F(a), "charges for medical evaluation, treatment and therapy, including all drugs, supplies, tests and associated chargeable items and events, shall be submitted to the employer or insurance carrier along with a bill or invoice for such charges, accompanied by records or notes, concerning the treatment or services submitted for payment, documenting the employee's condition and the appropriateness of the evaluation, treatment or therapy, with reference to the health care practice guidelines adopted pursuant to §2322C of this title, or documenting the pre-authorization of such evaluation, treatment or therapy."

What can I do if the payer will not pay me correctly?

A certified health care provider may file a petition to determine additional compensation due (DACD) with the Industrial Accident Board if they do not receive correct payment. Except for sole proprietors, providers will need to file their petition through an attorney. Sole proprietors may file a petition with or without an attorney.

Billing and payment for health care services is governed by Title 19 Del. C. §2322F.

Is the interest on medical bills owed if the claim is disputed for valid reasons but later determined to be compensable?

When compensability is contested, the billing procedures are governed by Title 19 Del. C. §2322F(l)(2).

Must bills be submitted on certain forms?

Pursuant to 19 DE Admin Code 1341, Sections 4.1[illegible]nd 4.2[illegible], require the use of the latest CMS-1500 and UB-04 forms.

Can you tell me if I am calculating a bill correctly?

No. We can provide general answers, as listed on this web page, but we do not have the resources to address individual calculations.

How should the payer handle a bill with incorrect codes? Can the payer alter the codes on a bill? Does the fee schedule allow for down-coding?

The payer should contact the provider and try to resolve such issues. If the parties cannot resolve the issue a petition may be filed with the state.

When an ambulance travels from one geozip to another, which one should count for billing?

The most common and universally accepted practice is to use the geozip of the place where the patient was picked up.

How do we reimburse assistant surgeons?

Pursuant to the Administrative Regulations for the Introduction and Fee Schedule Guidelines:

4.21.1.11 Surgical Assistant

4.21.1.11.1 Physician surgical assistant – For the purpose of reimbursement, a physician who assists at surgery is reimbursed as a surgical assistant. Assistant surgeons should use modifier 80 and are allowed twenty percent (20%) of the maximum reimbursement allowance (MRA) for the procedure(s).

4.21.1.11.2 Registered Nurse Surgical Assistant or Physician Assistant

- → 4.21.1.11.2.1 A physician assistant (PA), or registered nurses (NP) who have completed an approved first assistant training course, may be allowed a fee when assisting a surgeon in the operating room (O.R.).
- → 4.21.1.11.2.2 The maximum reimbursement allowance for the physician assistant or the registered nurse first assistant (RNFA) is twenty percent (20%) of the surgeon's fee for the procedure(s) performed.
- → 4.21.1.11.2.3 Under no circumstances will a fee be allowed for an assistant surgeon and a physician assistant or RNFA at the same surgical encounter.
- → 4.21.1.11.2.4 Registered nurses on staff in the O.R. of a hospital, clinic, or outpatient surgery center do not qualify for reimbursement as an RNFA."

How do we handle bilateral/multiple procedures?

The 19 DE Admin Code 1341 (Workers' Compensation Regulations) contain explanations for over 30 different modifiers, including the modifiers for bilateral and multiple procedures. Only those citations pertinent to this question are pasted below.

19 DE ADMIN CODE 1341, SECTION 4.6:

- 50 Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5 digit code. Note: There will be no reductions to the procedures billed with the modifier -50
- 51 Multiple Procedures: When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (e.g., vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes (see Appendix D). Note: There will be no reductions to the procedures billed with the modifier -51

19 DE ADMIN CODE 1341, SECTION 4.24:

4.24 Multiple Procedures

- 4.24.1 Multiple Procedure Reimbursement Rules Multiple procedures performed during the same operative session at the same operative site are reimbursed as follows:
  - 4.24.1.1 - One hundred percent (100%) of the allowable fee for the primary procedure
  - 4.24.1.2 - One hundred percent (100%) of the allowable fee for the second and subsequent procedures
- 4.24.2 Bilateral Procedure Reimbursement Rule
  - 4.24.2.1 - Physicians and staff are sometimes confused by the definition of bilateral. Bilateral procedures are identical procedures (i.e., use the same CPT code) performed on the same anatomic site but on opposite sides of the body.
  - 4.24.2.2 - There will be no reduction to the procedures billed with the modifier 50, RT or LT.
- 4.24.3 Multiple Procedure Billing Rules
  - 4.24.3.1 - The primary procedure, which is defined as the procedure with the highest RVU, must be billed with the applicable CPT code.
  - 4.24.3.2 - The second or lesser or additional procedure(s) may be billed by adding modifier 51 to the codes unless the procedure(s) is exempt from modifier 51, or 59, or qualifies as an add-on code.

How should providers bill for exposure surgeons as indicated in Part D of the low back practice guidelines?

In procedures where a surgeon provides exposure and another surgeon performs the primary surgical procedure, each surgeon may bill the CPT code or codes representing their respective part of the operation. Thus, co-surgery rules do not apply. For example, retroperitoneal exposure may be billed as CPT 49010 exploration of the retroperitoneum of the lumbar spine, or CPT 32100 major thoracotomy for the thoracic spine.

How would a utilization review (UR) provider become eligible to perform utilization review for the Delaware Workers' Compensation Health Care Payment System?

The Department of Labor issues a Request for Proposals (RFP) every 2 years and goes through the State of Delaware contracting process to award contracts to those URAC accredited organizations who will perform utilization review (UR) for the Workers' Compensation Health Care Payment System (HCPS). Accreditation must be in URAC's "Health Utilization Management" or "Workers' Compensation Utilization Management" programs. Interested parties may send an e-mail to hcpaymentquestions@delaware.gov if they would like to receive notice during the next contracting cycle. In the e-mail, explain that you would like to go on the mailing list to receive future RFP notices and include complete contact information (name, mailing address, e-mail address and phone number).

The OWC does not administer or govern an organization's internal policies or procedures regarding utilization review. However, Insurance Carriers and self-insured payers may only use a Utilization Review determination processed through the Office of Workers' Compensation to deny a certified health care provider's payment for treatment that applies to one of the practice guidelines in the Delaware Workers' Compensation Health Care Payment System.

How does the law on utilization review affect the process at the OWC?

The OWC issues two year contracts to utilization review (UR) organizations, per State of Delaware procurement requirements. These organizations provide UR for applicable State of Delaware workers' compensation cases. The process Carriers or self-insured employers must use to request a utilization review through the Delaware Office of Workers' Compensation is available by selecting "Utilization Review" from the menu located on the left side of this screen.

We also encourage payers to contact the OWC's Medical Component at 302-761-8200 or hcpaymentquestions@delaware.gov, if they need any extra guidance in preparing a Utilization Review Request.

What date should be used to begin counting the number of occurrences when determining a Utilization Review (UR)?

The Delaware Workers' Compensation Health Care Payment System (HCPS) became effective on 05-23-08. Utilization review is appropriate for proposed or retrospective treatment, visits, etcetera that occurred on or after 05/23/08 for the 5 initial practice guidelines (carpal tunnel, chronic pain, cumulative trauma disorder, low back, and shoulder). Occurrences involving cervical treatment would count after the 06/01/08 effective date of the cervical practice guidelines. Occurrences involving lower extremities would count after the 6/13/11 effective date of the lower extremities practice guidelines.

The workers' compensation health care practice guidelines may give additional guidance, such as occurrences allowed within a particular period of time (e.g. 12 months, etc.) or occurrences allowed when the injured worker demonstrates functional improvements.

What is the deadline for processing a Utilization Review (UR) request?

The Office of Workers' Compensation must receive (clocked-in) a UR request within 15 calendar days from the date of denial. Carriers and employers have 30 days to deny or pay a bill, and then 15 days from the date of that denial to request a UR. The total time required depends on the date the carrier or employer sent the denial; however, the total time may not exceed 45 days (30 days to pay or deny + 15 days to process UR = 45 total days). If the payer denies the bill prior to the 30 days specified in Title 19 Del. C. §2322F(h), then the payer still only has 15 days (clocked in at OWC) from that date to process the UR request.

The issue of compensability is separate from determining whether or not treatment is reasonable or necessary. If the carrier or self-insured employer challenges the compensability (e.g. not casually related to a work accident) of an injury, the injured worker must file a petition to determine compensation due (DCD). If the injury is deemed compensable, the hearing will also determine whether or not the treatment is reasonable and necessary.

Why is it important to specify each treatment modality(s) for review on the Request for Utilization Review form (item 8 on the form) versus using the blanket statement any and all treatment?

- The requester may not get a determination on the treatment they really wanted reviewed. This statement leaves the items reviewed up to the interpretation of the UR company. The Department of Labor (DOL) requires our UR contractors to follow URAC standards. As long as they ad-here to URAC standards, the UR company's interpretations of what to review are valid when the requester specifies "any and all treatment."
- The requester may get more determinations than they needed or wanted if the treatment is not identified. In addition, the requester may pay more when the UR company performs utilization review on more than one modality. Each treatment modality may be considered a separate utilization review. As long as the UR company adheres to URAC standards, they may determine what requires a separate utilization review when the requester does not list specific treatment modalities.
- The insurance carrier or self-insured employer must include "proof of denial" when they send a UR request to the DOL. Those denials usually list the specific treatment modalities. The "proof of denial" notice can give requesters a good starting point when determining what treatment modalities belong in item 9 on the "Request for Utilization Review" form. Keep in mind however, that item 9 must contain a description of the treatment modality and not just CPT/HCPCS codes.
- Insurance carriers or self-insured employers may also request a utilization review for proposed treatment, which is treatment the provider recommends. The health care provider may recommend treatment in the office notes or may ask for pre-authorization in a separate request to the carrier/self-insured employer, pursuant to subsection 5.4.3, 19 DE Admin Code 1341.

Please note, a health care treatment or service that recurs over time or a treatment or service the payer may believe will reoccur is not considered proposed treatment. The health care provider must propose the future health care treatment or service somewhere in the medical notes or in a separate preauthorization request.

How much does a Utilization Review (UR) cost?

NOTE: UR fees last increased on September 1, 2024

Some UR requests involve more than one utilization review, depending on what is written in item "8" of the "Request for Utilization Review" form. The Department of Labor requires our UR companies to perform a "like specialist" (level 3) review for any non-certified determinations. UR companies select "like specialists" per URAC standards. The fees for each utilization review performed are below. One UR request and subsequent bill may encompass one or all three levels of review, as well as the multiple utilization reviews that may stem from multiple treatment modalities based on item "8" of the "Request for Utilization Review" form.

LEVEL 1 REVIEW Nurse	$155
LEVEL 2 REVIEW Medical Director	$310
LEVEL 3 REVIEW Specialist	$470
LARGE FILE (>200 PAGES) Supplemental Fee	$0.75 per page
URGENT OR RUSH 48 hour Response	+$55

I have been treating a patient for ongoing pain after a work injury. The case is well over 6 months old, so care falls under the chronic guideline. My treatment has been helping the patient continue to work, however, further care is being denied as the number of treatments provided exceeds the guidelines.

The documentation shows my care is helping the patient, and is keeping them working. If I don't provide the care, the patient will get worse. What are my options?

PURSUANT TO 19 DEL.C. §2322C(6

"Services rendered by any health care provider certified to provide treatment services for employees shall be presumed, in the absence of contrary evidence, to be reasonable and necessary if such services conform to the most current version of the Delaware health care practice guidelines…"

AND PURSUANT TO 19 DEL.C. &SECT2322F(J),

"… An employer or insurance carrier may engage in utilization review to evaluate the quality, reasonableness and/or necessity of proposed or provided health care services for acknowledged compensable claims…"

Your best course of action in the case of treatment that relies on something more ambiguous than counting the number of visits is to include clear notes that specify the practice guidelines used, specify how the treatment helps the patient continue to work, and specify how the treatment complies (i.e. what are the functional gains) with the practice guidelines.

Pursuant to 19 Del.C. §2322C, Health Care Practice Guidelines, Section 1.0 in the Part B Chronic Pain Treatment Guidelines says:

"…Services rendered outside the Guidelines and/or variation in treatment recommendations from the Guidelines may represent acceptable medical care, be considered reasonable and necessary treatment and, therefore, determined to be compensable, absent evidence to the contrary, and may be payable in accordance with the Fee Schedule and Statute, accordingly…."

That citation in the chronic pain treatment guidelines does not take away the employers' or insurance carriers' ("payers") right to engage in utilization review as specified in 19 Del.C. §2322F(j) and does not guarantee the UR process will certify the provider's treatment. The UR reviewer's sole purpose is to determine whether or not treatment adheres to the health care practice guidelines (PGs) within the Delaware Workers' Compensation Health Care Payment System and is based on the medical documentation available to them at the time of the review. In order to seek payment for treatment that is non-certified through the UR process, a party must appeal the determination, pursuant to 19 DE Admin. Code 1341 (the "regulations"), Section 5.5.1 which says:

> → 5.5.1 If a party disagrees with the findings following utilization review, a petition may be filed with the Industrial Accident Board for de novo review. The decision of the utilization review company shall be forwarded by the Department of Labor, by Certified Mail, Return Receipt Requested, to the claimant, the claimant's attorney of record, the health care provider in question, and the employer or its insurance carrier.

In addition, 19 Del. C. §2361(c) gives the following 45 day deadline to appeal the UR determination,

> → (c) Notwithstanding the above, and in furtherance of and accordance with the provisions of § 2322F(j) of this title regarding utilization review, any utilization review decision issued pursuant to applicable rules and regulations promulgated pursuant to § 2322F(j) of this title shall be final and conclusive as to any interested party unless within 45 days from the date of receipt of the utilization review decision any interested party files a petition with the Industrial Accident Board for de novo review.

What are the injured workers' options if a carrier will not pre-authorize a health care service and/or treatment (e.g. surgery), and the certified health care provider will not perform the treatment and/or health care service without a preauthorization?

Prior to 6/13/11, the utilization review program did not require carriers or self-insured employers to respond to a preauthorization request, although they could. Effective 6/13/11, the following regulations were added to 19 DE Admin. Code 1341, Section 5.4, regarding utilization review:

- 5.4.3 In the instance of a compensable claim where the treatment is outside the applicable Practice Guideline for which the health care provider requests pre-authorization but the employer/carrier advises that it does not pre-authorize treatment, such response should be interpreted as tantamount to a denial of such treatment so that the claimant may file a Petition with the IAB to determine whether the treatment is compensable.
- 5.4.4 In the instance of a compensable claim in which open surgery is recommended by the health care provider and stated by him/her to be within the applicable Practice Guideline, the following procedure shall be followed to facilitate resolution of payment for such treatment: The operating surgeon must specify the particular surgery to be performed and must certify in writing that: (5.4.4.1) the surgery is causally related to the work accident and (5.4.4.2) the surgery is within the Practice Guideline, with specific reference to the Practice Guideline provision relied upon.
- 5.4.4.3 The information set forth above must be set forth by the operating surgeon in a separate written report, not through a copy of office notes and/or records. The employer/carrier must within 30 days from receipt of the above either accept/pre-authorize or deny such treatment. If the treatment is denied as non-compliant with the Practice Guidelines, it must be referred to Utilization Review within 15 days of date of denial in accordance with §2322F(h)(j). If the treatment is denied as not causally related to the compensable work accident, the claimant may file a Petition with the Industrial Accident Board to determine whether the treatment is compensable. If the employer/carrier neither accepts/pre-authorizes nor denies the treatment within the 30-day period referenced above, then the treat-ment will be deemed compensable if performed.

Keep in mind, utilization review does not pertain to causal relationship issues. If the carrier or self-insured employer disputes whether or not an injury receiving treatment was causally related to a work accident, the injured worker (or his/her attorney) may file a petition to **determine compensation due with the OWC in order to establish the claim.**

What is the peer-to-peer conversation as part of the utilization review process?

In response to requests from certified health care providers, the Delaware Department of Labor, Office of Workers' Compensation added a "peer-to-peer conversation to the utilization review (UR) process. Effective August, 2010, the like-specialist reviewer must make two attempts to reach the provider(s) under review prior to issuing a non-certification determination. This extra step allows provider(s) under review an opportunity to clarify which section(s) of the Delaware workers' compensation health care practice guidelines the provider(s) used to treat the injured worker. If the reviewer cannot reach the health care provider(s) after two attempts during normal 8-5 business hours, then the non-certification determination stands. Once the reviewer issues a UR determination, a party's only recourse is to appeal it by filing a de novo petition with the Industrial Accident Board, pursuant to 19 Del.C. §2322F(j)

Who has to become certified to treat injured workers?

All providers who bill must be certified. The two modifications/exceptions are as follows:

Hospital Modification: Providers treating an injured worker during his/her period of inpatient or outpatient hospitalization. In that circumstance, only physicians, chiropractors and physical therapists in the hospital setting need to be individually certified. All other personnel employed by a hospital providing treatment to an injured worker during his/her period of inpatient or out patient hospitalization are certified as a group by an authorized person/agent of the hospital.

Does the DOL issue certification numbers to certified health care providers?

No. All users may find the entire certified provider list on the Health Care Payment System (HCPS) web page, so the DOL decided not to issue certification numbers. As of 6/1/09, this information was removed from the Physicians Report of Workers' Compensation Injury ("Physician's Form").

What CPT code should providers use for the physician's report (provider form) and what is the fee? When should physicians fill out the form?

Use the CPT code 99080 for the physician's report (provider form). The health care provider most responsible for the injured worker's care fills out the physician's form at the first visit and at any subsequent visit where a change occurs in the injured worker's ability to return to work. If the injured worker does not miss time, write "no lost time" on the form at the initial visit. When more than one physician treats an injured worker, only the physician most responsible for the patient's care would fill out the form.

When should I fill out the provider or employer forms?

Provider – For new patients, at the first visit since the new law went into effect on 5/23/08 and any time the health care provider most responsible for the injured workers' care feels a change occurred in the injured workers' ability to return to work, which would include a closing form when the health care provider releases the injured worker from care. For instance, if an injured worker might now qualify for a modified duty, the provider would fill out the form.

Employer – Effective 6/27/13, the employer form provision in 19 Del. C. §2322E(d) changed to the following,

→ (d) Within 14 days of the issuance of an Agreement As To Compensation to an employee for any period of total disability, the employer shall provide to the health care provider/physician most responsible for the treatment of the employee's work-related injury and to the employer's insurance carrier, if applicable, a report of the modified-duty jobs which may be available to the employee. The insurance carrier for an insured employer shall send to such employer the aforementioned report for completion, and shall be independently responsible for providing a completed report of modified-duty jobs to the health care provider–physician. The health care provider portion of the employer's modified duty availability report must be signed and returned by the health care provider within 14 days of the next date of service after receipt of the form from the employer, but not later than 21 days from the health care provider's receipt of such form.

How does HIPAA affect workers' compensation?

The U.S. Department of Health and Human Services, Office of Civil Rights (OCR), administers the Health Insurance Portability and Accountability Act (HIPAA). It has issued guidelines. Open this document with ReadSpeaker docReader that indicate covered providers may disclose health information to workers' compensation insurers, state administrators, employers, and other entities involved in the workers' compensation system, to the extent disclosure is necessary to comply with, or is required by, state law, or to obtain payment.

The guidelines include a number of frequently asked questions. For more information, please contact the U.S. Department of Health and Human Services.

Are any injured workers exempt from coverage under the Delaware Workers' Compensation Act?

Yes. For exemptions please refer to Delaware Code Title 19, Chapter 23, Sections 2307 and 2308.

In addition, seaman, maritime workers, railroad workers and federal employees are covered under federal workers' compensation law. An injured worker covered under federal law would need to contact the appropriate federal office depending on the location of the work accident.

Where can I find a list of the 7/6/09, 6/27/13, and 7/15/14 changes to Title 19 Del.C. §2322?

The Governor signed into law Senate Bill No. 38 (145th General Assembly) on 7/6/09, House Bill No. 175 (147th General Assembly) on 6/27/13, House Bill No. 373 (147th General Assembly on 7/15/14 and House Bill No. 166 (148th General Assembly) on 7/27/15. All bills that pass into law are incorporated into the Delaware Code.

What are the effective dates for each of the Delaware workers' compensation health care practice guidelines?

Users may access the health care practice guidelines on the DOL web page at the link below:

Office of Worker's Compensation: Medical Component Unit

For treatment that occurred on or after May 23, 2008, 5 practice guidelines went into effect.

→ Part A – Carpal Tunnel Syndrome
→ Part B – Chronic Pain
→ Part C – Cumulative Trauma Disorder
→ Part D – Low Back
→ Part E – Shoulder

For treatment that occurred on or after June 1, 2009, the 6th practice guideline went into effect.

→ Part F – Cervical

For treatment that occurred on or after June 13, 2011, the 7th practice guideline went into effect.

→ Part G – Lower Extremities