# 1000 DEPARTMENT OF LABOR
## 1300 Division of Industrial Affairs
## 1340 The Office of Workers' Compensation

## 1341 Workers' Compensation Regulations

**1.0 Purpose and Scope**

1.1 Section **2322B**, **Chapter 23, Title 19, Delaware Code** authorizes and directs the Department within 180 days from the first meeting of the Health Care Advisory Panel to adopt a Health Care Payment System by regulation after promulgation by the Health Care Advisory Panel.

1.2 Section **2322B, Chapter 23, Section 19, Delaware Code**, authorizes and directs the Health Care Advisory Panel to adopt and recommend, a coordinated set of instructions and guidelines to accompany the health care payment system, to the Department for adoption by regulation.

1.3 Section **2322B (c)**, **Chapter 23, Title 19, Delaware Code** establishes the formula based upon historical data required to determine the Fee Schedule Amounts for professional services.

1.4 Section **2322B (e)**, **Chapter 23, Title 19, Delaware Code** establishes the amount of reimbursement for a procedure, treatment or service to be eighty-five (85%) of the actual charge as of November 1, 2008, if a specific fee is not set forth in the Fee Schedule Amounts.

1.5 Section **2322B (g), Chapter 23, Title 19, Delaware Code** establishes separate service categories.

1.6 Section 2**322B (h), Chapter 23, Title 19, Delaware Code** establishes the Hospital fees developed for the Health Care Payment System.

1.7 Section **2322B (i), Chapter 23, Title 19, Delaware Code** establishes the Ambulatory Surgical Treatment Center fees developed for the Health Care Payment System.

1.8 The fees to be established in Sections 2322B (k)(l) and (m) shall be promulgated and recommended by the Health Care Advisory Panel to the Department before the effective date of the regulation.

1.9 Section **2322D, Chapter 23, Title 19, Delaware Code** authorizes and directs the Department to adopt by regulation complete rules and regulations relating to Health Care Provider Certification within one (1) year after the first meeting of the Health Care Advisory Panel.

1.10 Section **2322E, Chapter 23, Section 19, Delaware Code**, authorizes and directs the Health Care Advisory Panel to approve, propose and recommend to the Department the adoption by regulation of consistent forms for the health care providers ("HCAP Forms").

**11 DE Reg. 920 (01/01/08)**

**2.0 Definitions**

As used in this regulation:

"**Certification**" means the certification pursuant to **19 Del.C. §2322D**, required for a Health Care Provider to provide treatment to an employee, pursuant to Delaware's Workers' Compensation Statute.

"**Department**" means the Department of Labor.

"**Fee Schedule Amounts**" mean the fees as set forth by the Health Care Payment System.

"**HCAP Forms**" means the standard forms for the provision of health care services set forth in Section 2322E, Chapter 23, Title 19, **Delaware Code**.

"**Health Care Advisory Panel**" or "**HCAP**" means the seventeen (17) members appointed by the Governor by and with the consent of the Senate to carry out the provisions of **Chapter 23, Title 19, Delaware Code**.

"**Health Care Payment System**" means the comprehensive fee schedule promulgated by the Health Care Advisory Panel to establish medical payments for both professional and facility fees generated on workers' compensation claims.

"**Health Care Provider Application for Certification**" means the Department's approved application form which Health Care Providers must submit to the Department to so that pre-authorization of each health care procedure, office visit or health care service to be provided to the employee is not required.

"**Health Care Providers**" for the purposes of Certification includes physicians, chiropractors and physical therapists providing treatment to an injured worker during his/her period of inpatient or outpatient hospitalization; all other personnel employed by a hospital providing treatment to an injured worker during his/her period of inpatient or outpatient hospitalization are excluded from the Certification process.

"**Utilization Review**" means the utilization review program and associated procedures to guide utilization of health care treatments in workers' compensation as set forth in Section 2322F(j), Chapter 23, Title 19, **Delaware Code.**

**3.0 Health Care Provider Certification**

3.1 **Section 2322D(a), Chapter 23, Title 19, Delaware Code** establishes the minimum certification requirement to be certified as a Health Care Provider:

3.1.1 With regard to the Certification of any hospital facility providing inpatient and/or outpatient services, the person completing and signing the Health Care Provider Application for Certification on behalf of the hospital shall have the authority to do so and must attest to and be responsible for the completion of all of the requirements set forth on the Health Care Provider Application for Certification.

3.1.2 Services provided by an emergency department of a hospital pursuant to **§2322B(h)(3) of Chapter 23, Title 19, Delaware Code** shall not be subject to the requirement of Certification.

3.1.3 The provisions of this section shall apply to all treatment of employees provided after the effective date of these rules and regulations regardless of the date of injury.

3.1.4 Notwithstanding the provisions of **§2322D of Chapter 23, Title 19, Delaware Code**, any health care provider may provide services during one office visit, or other single instance of treatment, without first having obtained prior authorization from the employer if self insured, or the employer's insurance carrier, and receive reimbursement for reasonable and necessary services directly related to the employee's injury or condition at the health care provider's usual and customary fee, or the maximum allowable fee pursuant to fee schedule adopted pursuant to **Section 2322B of Chapter 23, Title 19, Delaware Code** whichever is less.

3.1.5 The allowance of reimbursement for the employee's first contact with any health care provider for treatment of the injury as described in 3.1.4 is further limited to instances when the health care provider believes in good faith, that the injury or occupational disease was suffered in the course of the employee's employment.

3.2 Completed Certification should be mailed to:

Mr. John F. Kirk, III
State of Delaware Department of Labor
Office of Workers' Compensation
P.O. Box 9954M
Wilmington, DE 19809-9954

3.3 Instructions and provisions for completing the Certification Form online will be published on the Office of Workers' Compensation website when available.

**4.0 Workers' Compensation Health Care Payment Rates for Physicians and Hospitals (the "Fee Schedule")**

Introduction and Purpose

The intent of the health care payment system developed pursuant to Delaware's Workers' Compensation Act ("Act") is not to establish a "pushdown" system, but is instead to establish a system that eliminates outlier charges and streamlines payments by creating a presumption of acceptability of charges implemented through a transparent process, involving relevant interested parties, that

prospectively responds to the cost of maintaining a health care practice, eliminating cost shifting among health care service categories, and avoiding institutionalization of upward rate creep.

The maximum allowable payment for health care treatment and procedures covered under the Workers' Compensation Act shall be the lesser of the health care provider's actual charges or the fee set by the payment system. The payment system will set fees at ninety percent (90%) of the 75$^{th}$ percentile of actual charges within the geozip where the service or treatment is rendered, utilizing information contained in employers' and insurance carriers' national databases. For purposes of the Act, "geozip" means an area defined by reference to United States ZIP Codes; Delaware shall consist of one "197 geozip" (comprised of all areas within the State where the address has a ZIP Code beginning with the three digits 197 or 198), and one "199 geozip" (comprised of all areas within the State where the address has a ZIP Code beginning with the three digits 199). If a geozip does not have the necessary number of charges and fees to calculate a valid percentile for a specific procedure, treatment or service, the Health Care Advisory Panel created pursuant to **19 Del.C. §2322(A)**, in its discretion may combine data from Delaware's two geozips for a specific procedure, treatment, or service. In the event that the Health Care Advisory Panel determines that there is insufficient data to calculate a valid percentile for a procedure, treatment or service, or that data from a commercial vendor is not sufficiently reliable to implement a payment system for professional services for a specific procedure, treatment or service, then the Health Care Advisory Panel may recommend an alternative method for a payment system for professional charges.

Three (3) years after the effective date of the Act, January 17, 2007, the Health Care Advisory panel shall review the geozip reporting system and make a recommendation concerning whether the State should operate its workers' compensation health care payment system on a geozip basis or on a single statewide basis.

If an employer or an insurance carrier contracts with a provider for the purpose of providing services under the Act, the rate negotiated in any such contract shall prevail.

This document is intended to assist with fee schedule application, and to ensure correct billing and reimbursement on workers' compensation medical claims. This document is NOT intended, and should not be construed, as a utilization review guide or practice manual.

**Reference Materials**

The health care payment system and fee schedule is in accordance with the following documents, including codes, guidelines and modifiers:

- *Current Procedural Terminology*, copyright, American Medical Association, 515 N. State St., Chicago, IL 60610, Chicago, 2006;
- *HCPCS Level II*, U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 7500 Security Blvd., Baltimore, MD 21244, Baltimore, 2006;
- *National Correct Coding Policy Manual in Comprehensive Code Sequence for Part B Medicare Carriers, Version 12.0,* U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 7500 Security Blvd., Baltimore, MD 21244, Baltimore, 2006;
- *Relative Value Guide*, copyright, American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, IL 60068-2573, Park Ridge, 2006;
- Diagnosis-Related Group (DRG) classification system, Centers for Medicare and Medicaid Services (CMS), *Federal Register*, Vol. 70, No. 155, August 2005.

4.1 HCPCS (Healthcare Common Procedure Coding System) (Level II)

The health care payment system requires that services be reported with the Healthcare Common Procedural Coding System Level 2 ("HCPCS Level 2"), or CPT codes that most comprehensively describe the services performed. Proprietary bundling edits more restrictive than the National Correct Coding Policy Manual in Comprehensive Code Sequence for Part B Medicare Carriers, Version 12.0, U.S. Department of Health and Human Services, Centers for Medicare and Medicare Services, 7500 Security Boulevard, Baltimore, Maryland, 21244, 2006, no later dates or editions, shall be prohibited.

Bundling edits is the process of reporting codes so that they most comprehensively describe the services performed.

4.2 Professional Services/CPT Code Set

4.2.1 Unless otherwise specified herein, the payment system for professional services shall conform to the Current Procedural Terminology ("CPT"), American Medical Association, 515 North State Street, Chicago, Illinois, 60610, 2006, no later dates or editions.

4.2.2 The fee schedule defers to guides and descriptions in the CPT Code Set in establishing the correct classification for health care services.

4.3 Physician/Health Care Provider Services

4.3.1 The maximum allowable payment for health care treatment and procedures shall be the lesser of the health care provider's actual charges or ninety percent (90%) of the 75$^{th}$ percentile of actual charges within the geozip where the service or treatment is rendered, utilizing information contained in employers' and insurance carriers' national databases. If an employer or insurance carrier contracts with a provider for the purpose of providing services under the Act, the rate negotiated in such contract shall prevail.

4.3.2 Whenever the health care payment system does not set a specific fee for a procedure, treatment or service in the schedule, the amount of reimbursement shall be eighty-five percent (85%) of actual charge ("POC 85"), which actual charge will be fixed as of 11/1/08 and subsequent to such date will be subject to verification, audit and/or review by the Department of Insurance. Reasonable costs of such review or audit shall be reimbursed to the Department of Insurance by the health care provider whose billing is audited. From the effective date of this regulation through and including 10/31/08, the "POC 85" charges, if contested, will be subject to review pursuant to Hearing to be conducted before the Industrial Accident Board.

4.3.3 The payment system will be adjusted yearly from the date the Health Care Advisory Panel recommended adoption of the fee schedule, November 14, 2007, 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.

4.4 Modifiers

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.

4.5 Anesthesia Services

4.5.1 The maximum allowable payment for anesthesia treatment, procedures or services shall be the lesser of the health care provider's actual charges or ninety percent (90%) of the 75$^{th}$ percentile of actual charges within the geozip where the treatment, procedure or service is rendered, utilizing information contained in employers' and insurance carriers' national databases. If an employer or insurance carrier contracts with a provider for the purpose of providing services under the Act, the rate negotiated in such contract shall prevail.

4.5.2 Whenever the health care payment system does not set a specific fee for an anesthesia treatment, procedure or service in the schedule, the amount of reimbursement shall be eighty-five percent (85%) of actual charge ("POC 85") for such service as of October 31, 2006, subject to verification, review and/or audit by the Department of Insurance. Reasonable costs of such review or audit shall be reimbursed to the Department of Insurance by the health care provider whose billing is audited.

4.5.3 The payment system will be adjusted yearly from the date the Health Care Advisory Panel recommended adoption of the fee schedule, November 14, 2007, and each year thereafter the Department of Labor shall make an automatic adjustment to the maximum payment for an anesthesia treatment, procedure and/or service in effect in January of that year. The Department of Labor shall increase or decrease the maximum payment by the percentage

change of increase or decrease in the Consumer Price Index-Urban, U.S. City Average, All Items, as published in the United States Bureau of Labor Statistics.

4.6 Ambulatory Surgical Treatment

4.6.1 Fees billed for services provided to injured workers pursuant to the Act by an Ambulatory Surgical Treatment Center ("ASTC") shall be reimbursed at a rate equal to eighty-five percent (85%) of each ASTC's actual charges for services as of October 31, 2006. Verification that such billing is performed in compliance with **19 Del.C. §2322B(i)(1)** shall be provided by each ASTC to the Office of Workers' Compensation within sixty (60) days of the completion and issuance of audited financial statements to the ASTC by its independent financial auditors. Such verification shall be subject to further review or audit by the Department of Insurance. Reasonable costs of such review or audit for purposes of the above-referenced section of the Act shall be reimbursed to the Department of Insurance by the ASTC whose billing is audited. The ASTC fee determination mechanism adopted pursuant to this subsection shall apply to all services provided after the effective date of the regulation implementing the fee schedule and regardless of the date of injury.

4.6.2 The payment system will be adjusted yearly from the date the Health Care Advisory Panel recommended adoption of the fee schedule, November 14, 2007, and each year thereafter the Department of Labor shall make an automatic adjustment to each ASTC's reimbursement rates as derived pursuant to the above for procedures, treatments or services in effect in January of that year. The amount payable to each ASTC pursuant to the above shall be adjusted annually by the Department of Labor in accordance with the Consumer Price Index--Urban, U.S. City Average for Medical Care, as published by the United States Bureau of Labor Statistics. The adjustment factor referenced above shall be reviewed by the Health Care Advisory Panel three (3) years after the effective date of this section and the Panel shall make a recommendation concerning the continued use of the Consumer Price Index for Medical Care, or the adoption of a different index for cost adjustments in fees for ASTC services.

4.7 Dental Services

4.7.1 The maximum allowable payment for dental treatment, procedures or services shall be the lesser of the health care provider's actual charges of ninety percent (90%) of the 75$^{th}$ percentile of actual charges within the geozip where the treatment, procedure or service is rendered, utilizing information contained in employers' and insurance carriers' national databases. If an employer or insurance carrier contracts with a provider for the purpose of providing services under the Act, the rate negotiated in such contract shall prevail.

4.7.2 Whenever the health care payment system does not set a specific fee for a dental treatment, procedure or service in the schedule, the amount of reimbursement shall be eighty-five percent (85%) of actual charge ("POC 85") for such service as of October 31, 2006, subject to verification, review and/or audit by the Department of Insurance. Reasonable costs of such review or audit shall be reimbursed to the Department of Insurance by the dental practitioner whose billing is audited.

4.7.3 The payment system will be adjusted yearly from the date the Health Care Advisory Panel recommended adoption of the fee schedule, November 14, 2007, and each year thereafter the Department of Labor shall make an automatic adjustment to the maximum payment for a dental treatment, procedure or service in effect in January of that year. The Department of Labor shall increase or decrease the maximum payment by the percentage change of increase or decrease in the Consumer Price Index-Urban, U.S. City Average, All Items, as published by the United States Bureau of Labor Statistics.

4.8 Emergency Department of a Hospital

4.8.1 Services provided by an emergency department of a hospital, or any other facility subject to the Federal Emergency Medical Treatment and Active Labor Act, 42 United States Code §1395dd, et seq., and any emergency medical services provided in a pre-hospital setting by ambulance attendants and/or paramedics, shall be exempt from the healthcare payment system and shall not be subject to the requirement that a health care provider be certified

pursuant to **19 Del.C. §2322D**, requirements for preauthorization of services, or the health care practice guidelines adopted pursuant to **19 Del.C. §2322C**.

4.8.2 Upon admission to a hospital and discharge from an emergency department, hospital charges shall be subject to that which is set forth in the section below titled "Hospital".

4.9 Hospital

4.9.1 Hospital fees billed for inpatient and outpatient services provided to injured workers pursuant to the Act shall be reimbursed at a rate equal to eighty-five percent (85%) of each hospital's actual charges for such services as of October 31, 2006, subject to adjustment as provided below. Verification that such billing is performed in compliance with the above and **19 Del.C. §2322B(h)** shall be provided by each hospital to the Office of Workers' Compensation within sixty (60) days of the completion and issuance of audited financial statements to the hospital by its independent financial auditors. Such verification shall be subject to further review or audit by the Department of Insurance. Reasonable costs of such review or audit for purposes of this section shall be reimbursed to the Department of Insurance by the hospital whose billing is audited.

4.9.2 The payment system will be adjusted yearly from the date the Health Care Advisory Panel recommended adoption of the fee schedule, November 14, 2007, with automatic adjustment to each hospital's reimbursement rates, as derived pursuant to **19 Del.C. §2322B(h)**, for procedures, treatments or services in effect in January of that year. The amount payable to each hospital pursuant to **19 Del.C. §2322B(h)** shall be adjusted annually by the Department of Labor in accordance with the Consumer Price Index--Urban, U.S. City Average for Medical Care, as published by the United States Bureau of Labor Statistics. The adjustment factor referenced above shall be reviewed by the Health Care Advisory Panel three (3) years after the effective date of the regulation implementing the fee schedule, and the Panel shall make a recommendation concerning the continued use of the Consumer Price Index for medical care, or the adoption of a different index for cost adjustments in fees for hospital services.

4.10 Allied Health Care Professional

An allied health care professional, such as a certified registered nurse anesthetist ("CRNA"), physician assistant ("PA") or nurse practitioner ("NP"), shall be reimbursed at the same rate as other health care professionals when the allied health care professional is performing, coding and billing for the same services as other health care professionals if a physician health care provider is physically present when the service or treatment is rendered, and shall be reimbursed at eight percent (80%) of the primary health care provider's rate if a physician health care provider is not physically present when the service or treatment is rendered.

4.11 Independently Operated Diagnostic Testing Facility

4.11.1 Charges of an independently operated diagnostic testing facility shall be subject to the professional services and HCPCS Level II health care payment system where applicable. An independent diagnostic testing facility is an entity independent of a hospital or physician's office, whether a fixed location, a mobile entity, or an individual non-physician practitioner, in which diagnostic tests are performed by licensed or certified non-physician personnel under appropriate physician supervision.

4.11.2 In the event that the professional services and HCPCS Level II health care payment system is inapplicable, the fee for reimbursement of independent diagnostic testing facility services shall be eight-five percent (85%) of actual charge ("POC 85") for such service as of October 31, 2006, subject to verification, review and/or audit by the Department of Insurance. Reasonable costs of such review or audit shall be reimbursed to the Department of Insurance by the health care provider whose billing is audited.

4.11.3 The payment system will be adjusted yearly from the date the Health Care Advisory Panel recommended adoption of the fee schedule, November 14, 2007, and each year thereafter the Department of Labor shall make an automatic adjustment to the maximum payment for a procedure, treatment or service in effect in January of that year. The Department of Labor shall increase or decrease the maximum payment by the percentage change of increase or

decrease in the Consumer Price Index--Urban, U.S. City Average, All Items, as published by the United States Bureau of Labor Statistics.

4.12 Pathology

4.12.1 The maximum allowable payment for pathology services and procedures shall be the lesser of the health care provider's actual charges or ninety percent (90%) of the 75th percentile of actual charges within the geozip where the pathology service or procedure is rendered, utilizing information contained in employers' and insurance carriers' national databases. If an employer or insurance carrier contracts with a provider for the purpose of providing services under the Act, the rate negotiated in such contract shall prevail.

4.12.2 Whenever the health care payment system does not set forth a specific fee for a pathology service or procedure in the schedule, the amount of reimbursement shall be eighty-five percent (85%) of actual charge ("POC 85") for such service or procedure as of October 31, 2006, subject to verification, review and/or audit by the Department of Insurance. Reasonable costs of such review or audit shall be reimbursed to the Department of Insurance by the health care provider whose billing is audited.

4.12.3 The payment system will be adjusted yearly from the date the Health Care Advisory Panel recommended adoption of the fee schedule, November 14, 2007, and each year thereafter the Department of Labor shall make an automatic adjustment to the maximum payment for a procedure, treatment or service in effect in January of that year. The Department of Labor shall increase or decrease the maximum payment by the percentage change of increase or decrease in the Consumer Price Index--Urban, U.S. City Average, All Items, as published by the United States Bureau of Labor Statistics.

4.13 Radiology

4.13.1 The maximum allowable payment for radiology treatment, procedures or services shall be the lesser of the health care provider's actual charges or ninety percent (90%) of the 75th percentile of actual charges within the geozip where the service or treatment is rendered, utilizing information contained in the employers' and insurance carriers' national databases. If an employer or insurance carrier contracts with a provider for the purpose of providing services under the Act, the rate negotiated in such contract shall prevail.

4.13.2 Whenever the health care payment system does not set forth a specific fee for a radiology treatment, procedure or service in the schedule, the amount for reimburse-ment shall be eighty-five percent (85%) of actual charge ("POC 85") for such service as of October 31, 2006, subject to verification, review and/or audit by the Department of Insurance. Reasonable costs of such review or audit shall be reimbursed to the Department of Insurance by the health care provider whose billing is audited.

4.13.3 The payment system will be adjusted yearly from the date the Health Care Advisory Panel recommended adoption of the fee schedule, November 14, 2007, and each year thereafter the Department of Labor shall make an automatic adjustment to the maximum payment for a procedure, treatment or service in effect in January of that year. The Department of Labor shall increase or decrease the maximum payment by the percentage change of increase or decrease in the Consumer Price Index--Urban, U.S. City Average, All Items, as published by the United States Bureau of Labor Statistics.

4.14 Pharmacy

4.14.1 Reimbursement for pharmacy services, prescription drugs and other pharmaceuticals is 100% of the Average Wholesale Price (AWP) as of October 31, 2006. Verification that such billing is performed in compliance with the above and **19 Del.C. §2322B** is subject to review or audit by the Department of Insurance. Reasonable costs of such review or audit for purposes of the above shall be reimbursed to the Department of Insurance by the provided whose billing is audited.

4.14.2 The payment system will be adjusted yearly from the date the Health Care Advisory Panel recommended adoption of the fee schedule, November 14, 2007, and each year thereafter the

Department of Labor shall make an automatic adjustment to the maximum payment for pharmacy services, prescription drugs and other pharma-ceuticals in effect in January of that year. The Department of Labor shall increase or decrease the maximum payment by the percentage change of increase or decrease in the Consumer Price Index--Urban, U.S. City Average, All Items, as published by the United States Bureau of Labor Statistics.

4.14.3 A prescription drug formulary has been adopted and recommended by the Health Care Advisory Panel which designates preferred prescription drugs and encourages the use of generic drugs over name brand drugs.

4.15 Durable Medical Equipment

4.15.1 The maximum allowable payment for durable medical equipment shall be the lesser of the health care provider's actual charges or ninety percent (90%) of the 75$^{th}$ percentile of actual charges within the geozip where the durable medical equipment is provided, utilizing information contained in employers' and insurance carriers' national databases. If an employer or insurance carrier contracts with a provider for the purpose of providing durable medical equipment under the Act, the rate negotiated in such contract shall prevail.

4.15.2 Whenever the health care payment system does not set a specific fee for durable medical equipment in the schedule, the amount of reimbursement shall be eighty-five percent (85%) of the provider's actual charge for such equipment as of October 31, 2006, subject to adjustment as provided below. Verification that such billing is performed in compliance with **19 Del.C. §2322B(h)** shall be subject to verification, review and/or audit by the Department of Insurance. Reasonable costs of such review or audit for purposes of the above and **19 Del.C. §2322B** shall be reimbursed to the Department of Insurance by the provider whose billing is audited.

4.15.3 The payment system will be adjusted yearly from the date the Health Care Advisory Panel recommended adoption of the fee schedule, November 14, 2007, and each year thereafter the Department of Labor shall make an automatic adjustment to the maximum payment for durable medical equipment in effect in January of that year. The Department of Labor shall increase or decrease the maximum payment by the percentage change of increase or decrease in the Consumer Price Index--Urban, U.S. City Average, All Items, as published by the United States Bureau of Labor Statistics.

4.16 Total Component/Professional Component, Technical Component

4.16.1 A total fee includes both the professional component and the technical component needed to accomplish the procedure. Explanations of the professional component and the technical component are listed below. The values listed in the Amount column represent the total reimbursement. Under no circumstance shall the combined amounts of the professional and technical components exceed the amount of the total component.

4.16.2 Professional Component: The professional component represents the reimbursement allowance of the professional services of the physician and is identified by the use of modifier 26. This includes examination of the patient when indicated, performance or supervision of the procedure, interpretation and written report of the examination, and consultation with the referring physician. Values in the PC Amount column are intended for the services of the professional for the professional component only and do not include any other charges. To identify a charge for a professional component only, use the five-digit code followed by modifier 26.

4.16.3 Technical Component: The technical component includes charges made by the institution or clinic to cover the services of the facilities. To identify a charge for a technical component only, use of the five-digit code followed by HCPCS Level II modifier TC.

4.17 Out-Of-State Service

If any procedure, treatment or service is rendered outside of the State of Delaware, the amount of reimbursement shall be the greater of (1) the amount set forth in a workers' compensation health care payment system or fee schedule adopted by the state in which the procedure, treatment or service is rendered, if such a schedule has been adopted, or (2) the amount that would be authorized by the payment system adopted pursuant to Delaware's Workers' Compensation Act if the service or

treatment were performed in the geozip where the injury occurred or where the employee was principally assigned. Charges for a procedure, treatment or service outside the State of Delaware shall be subject to the instructions, guidelines, and payment guides and policies in the health care payment system.

4.18 Billing and Payment for Health Care Services

4.18.1 Pursuant to **19 Del.C. §2322F,** 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 **19 Del.C. §2322C**, or documenting the preauthorization of such evaluation, treatment or therapy. The initial copy of the supporting notes or records shall be produced without separate or additional charge to the employer, insurance carrier or employee.

4.18.2 Those healthcare providers who obtained certification pursuant to **19 Del.C. §2322D** are not required to first preauthorize each health care procedure, office visit or health care service to be provided to an injured employee with the employer or insurance carrier.

4.18.3 Charges for hospital services and items supplied by a hospital, 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 which shall be documented in a nationally recognized uniform billing code format and as reference above, in sufficient detail to document the services or items provided, and any preauthorization of the services and items shall also be documented. The initial copy of the supporting medical notes or records shall be produced without separate or additional charge to the employer, insurance carrier or employee.

4.18.4 Payment for hospital services, including payment for invoices rendered for emergency department services, shall be made within thirty (30) days of the submission of a "clean claim" accompanied by notes documenting the employee's condition and the appropriateness of the evaluation, treatment or therapy.

4.18.5 Preauthorized evaluations, treatments or therapy shall be paid at the agreed fee within thirty (30) days of the date of submission of the invoice, unless the compliance with the preauthorization is contested, in good faith, pursuant to the utilization review system set forth in **19 Del.C. §2322F(j)** [see the rules and regulation regarding Utilization Review].

4.18.6 Treatments, evaluations and therapy provided by a certified health care provider shall be paid within thirty (30) days of receipt of the health care provider's bill or invoice together with records or notes as provided above and pursuant to **19 Del.C. §2322F**, unless compliance with the health care payment system or practice guidelines adopted pursuant to **19 Del.C. §§2322B or 2322C** is contested, in good faith, pursuant to the utilization review system as referenced above.

4.18.7 Denial of payment of health care services provided pursuant to the Act, whether in whole or in part, shall be accompanied with written explanation for reason for denial.

4.18.8 In the event that a portion of a health care invoice is contested, the uncontested portion shall be paid without prejudice to the right to contest the remainder. The time limits set forth above and in §2322F shall apply to payment of all uncontested portions of health care payments.

4.18.9 An employer or insurance carrier shall be required to pay a health care invoice within thirty (30) days of receipt of the invoice as long as the claim contains substantially all the required data elements necessary to adjudicate the invoice, unless the invoice is contested in good faith. If the contested invoice pertains to an acknowledged compensable claim and the denial is based upon compliance with the health care payment system and/or health care practice guidelines, it shall be referred to utilization review. Unpaid invoices shall incur interest at a rate of one percent (1%) per month payable to the provider. A provider shall not hold an employee liable for costs related to non-disputed services for a compensable injury and shall not bill or

attempt to recover from the employee the difference between the provider's charge and the amount paid by the employer or insurance carrier on a compensable injury.

4.18.10 If, following a hearing, the Industrial Accident Board determines that an employer, an insurance carrier, or health care provider failed in its responsibilities under **19 Del.C. §§2322B, 2322C, 2322D, 2322E or 2322F**, it shall assess a fine of not less than $1,000.00 nor more than $5,000.00 for violations of said sections, such fines shall be payable to the Workers' Compensation Fund.

4.19 Fees for Non-Clinical Services

4.19.1 Pursuant to **19 Del.C. §2322B(m)**, fees for certain non-clinical services are set as follows, and will be periodically revised upon recommendation of the Health Care Advisory Panel to reflect changes in the cost of providing such services:

4.19.1.1 Retrieving, copying and transmitting existing medical reports and records, to include copying of medical notes and/or records supporting a bill or invoice for charges for treatment or services:

- $25.00 for search and retrieval
- $1.25 per page for first 20 pages
- $.90 per page for pages 21 through 60
- $.30 per page for pages 61 and thereafter

4.19.1.2 Testimony by a physician for non-video deposition shall not exceed $2,000.00; for video deposition: $500.00 additional;

4.19.1.3 Live testimony by a physician at any hearing or proceeding shall not exceed $3,500.00;

4.19.1.4 Completion and transmission of any Statutorily required report, form or document by a physician/health care provider: $30.00.

4.20 Effective Date

4.20.1 The health care payment system shall apply to all services provided after the effective date of the health care payment system regulations and regardless of date of injury.

4.20.2 The Department of Labor of the State of Delaware reserves the authority to determine applicability of all rules of the fee schedule. Any physician, other medical professional, or other entity having questions regarding applicability to their individual reimbursement as it applies to the fee schedule, should direct any such question to the Department of Labor or to such other authority as directed by the Department of Labor.

feeshcedule.pdf Payment Rates for Physicians and Hospitals (Fee Schedule)

## DOWC PREFERRED DRUG LIST

Use the formulary below only for NSAID analgesics, opiod analagesics, skeletal muscle relaxants. Physicians are encouraged to prescribe generic drugs. If the physician feels it is medically necessary to prescribe a non-preferred drug and there is no generic equivalent then it can be done without prior authorization. Please note that the Reference Trade Name listed below is used only as an example of the generic drug.

The use of sustained release/controlled release medication may be used when a continuous around-the-clock analgesic is needed for moderate to severe pain requiring treatment for an extended period of time.

| ANALGESICS: NSAIDs | |
|---|---|
| **PREFERRED DRUG** | **Reference Trade Name** |
| DICLOFENAC POTASSIUM 50MG TABLET ORAL | *CATAFLAM 50 MG TABLET* |
| DICLOFENAC SODIUM 100MG TAB.SR 24H ORAL | *VOLTAREN-XR 100 MG TABLET* |
| DICLOFENAC SODIUM 25MG TABLET DR ORAL | *VOLTAREN 25 MG TABLET EC* |
| DICLOFENAC SODIUM 50MG TABLET DR ORAL | *VOLTAREN 50 MG TABLET EC* |
| DICLOFENAC SODIUM 75MG TABLET DR ORAL | *VOLTAREN 75 MG TABLET EC* |
| DIFLUNISAL 250MG TABLET ORAL | *DOLOBID 250MG TABLET* |

| | |
|---|---|
| DIFLUNISAL 500MG TABLET ORAL | *DOLOBID 500 MG TABLET* |
| ETODOLAC 200MG CAPSULE ORAL | *LODINE 200 MG CAPSULE* |
| ETODOLAC 300MG CAPSULE ORAL | *LODINE 300 MG CAPSULE* |
| ETODOLAC 400MG TAB.SR 24H ORAL | *LODINE XL 400MG TABLET SA* |
| ETODOLAC 400MG TABLET ORAL | *LODINE 400 MG TABLET* |
| ETODOLAC 500MG TAB.SR 24H ORAL | *LODINE XL 500 MG TABLET SA* |
| ETODOLAC 500MG TABLET ORAL | *LODINE 500MG TABLET* |
| ETODOLAC 600MG TAB.SR 24H ORAL | *LODINE XL 600MG TABLET SA* |
| FENOPROFEN CALCIUM 200MG CAPSULE ORAL | *NALFON 200 MG PULVULE* |
| FENOPROFEN CALCIUM 300MG CAPSULE ORAL | *NALFON 300 MG CAPSULE* |
| FENOPROFEN CALCIUM 600MG TABLET ORAL | *NALFON 600MG TABLET* |
| FLURBIPROFEN 100MG TABLET ORAL | *ANSAID 100 MG TABLET* |
| FLURBIPROFEN 50MG TABLET ORAL | *ANSAID 50MG TABLET* |
| IBUPROFEN 100MG TAB CHEW ORAL | *ADVIL 100 MG TABLET CHEW* |
| IBUPROFEN 100MG TABLET ORAL | *MOTRIN 100MG CAPLET* |
| IBUPROFEN 100MG/5ML GEL ORAL | *ELIXSURE IB SUSPENSION* |
| IBUPROFEN 100MG/5ML ORAL SUSP ORAL | *MOTRIN 100 MG/5 ML SUSPENSION* |
| IBUPROFEN 200MG CAPSULE ORAL | *ADVIL MIGRAINE 200 MG CAPSULE* |
| IBUPROFEN 200MG TABLET ORAL | *MOTRIN IB 200 MG CAPLET* |
| IBUPROFEN 300MG TABLET ORAL | *MOTRIN 300 MG TABLET* |
| IBUPROFEN 400MG TABLET ORAL | *MOTRIN 400 MG TABLET* |
| IBUPROFEN 40MG/ML DROPS SUSP ORAL | *MOTRIN 40MG/ML SUSP DROPS* |
| IBUPROFEN 50MG TAB CHEW ORAL | *MOTRIN 50MG TABLET CHEWABLE* |
| IBUPROFEN 600MG TABLET ORAL | *MOTRIN 600 MG TABLET* |
| IBUPROFEN 800MG TABLET ORAL | *MOTRIN 800 MG TABLET* |
| INDOMETHACIN 25MG CAPSULE ORAL | *INDOCIN 25MG CAPSULE* |
| INDOMETHACIN 25MG/5ML ORAL SUSP ORAL | *INDOCIN 25 MG/5 ML SUSPENSION* |
| INDOMETHACIN 50MG CAPSULE ORAL | *INDOCIN 50MG CAPSULE* |
| INDOMETHACIN 50MG RECTAL SUPPOSITORY | *INDOCIN 50 MG SUPPOSITORY* |
| INDOMETHACIN 75MG CAPSULE SA ORAL | *INDOCIN SR 75MG CAPSULE SA* |
| KETOPROFEN 100MG PELLETED 24HR CAPSULE ORAL | *ORUVAIL 100MG CAPSULE SA* |
| KETOPROFEN 12.5MG TABLET ORAL | *ORUDIS KT 12.5 MG TABLET* |
| KETOPROFEN 150MG PELLETED 24HR CAPSULE ORAL | *ORUVAIL 150MG CAPSULE SA* |
| KETOPROFEN 200MG PELLETED 24HR CAPSULE ORAL | *ORUVAIL 200 MG CAPSULE SA* |
| KETOPROFEN 25MG CAPSULE ORAL | *ORUDIS 25MG CAPSULE* |
| KETOPROFEN 50MG CAPSULE ORAL | *ORUDIS 50MG CAPSULE* |
| KETOPROFEN 75MG CAPSULE ORAL | *ORUDIS 75MG CAPSULE* |
| KETOROLAC TROMETHAMINE 10MG TABLET ORAL | *TORADOL 10 MG TABLET* |
| MECLOFENAMATE SODIUM 100MG CAPSULE ORAL | *MECLOMEN 100MG CAPSULE* |
| MECLOFENAMATE SODIUM 50MG CAPSULE ORAL | *MECLOMEN 50MG CAPSULE* |
| NABUMETONE 500MG TABLET ORAL | *RELAFEN 500 MG TABLET* |
| NABUMETONE 750MG TABLET ORAL | *RELAFEN 750 MG TABLET* |
| NAPROXEN 125MG/5ML ORAL SUSP ORAL | *NAPROSYN 125 MG/5 ML SUSPENSION* |
| NAPROXEN 250MG TABLET ORAL | *NAPROSYN 250 MG TABLET* |
| NAPROXEN 375MG TABLET DELAYED-RELEASE ORAL | *EC-NAPROSYN 375 MG TABLET* |

| | |
|---|---|
| NAPROXEN 375MG TABLET ORAL | *NAPROSYN 375 MG TABLET* |
| NAPROXEN 500MG TABLET DELAYED-RELEASE ORAL | *EC-NAPROSYN 500 MG TABLET* |
| NAPROXEN 500MG TABLET ORAL | *NAPROSYN 500 MG TABLET* |
| NAPROXEN SODIUM 220MG TABLET ORAL | *ALEVE 220 MG TABLET* |
| NAPROXEN SODIUM 275MG TABLET ORAL | *ANAPROX 275 MG TABLET* |
| NAPROXEN SODIUM 550MG TABLET ORAL | *ANAPROX DS 550 MG TABLET* |
| NAPROXEN SODIUM 550MG TABLET SA ORAL | *NAPRELAN 500 TABLET SA* |
| OXAPROZIN 600MG TABLET ORAL | *DAYPRO 600 MG CAPLET* |
| PIROXICAM 10MG CAPSULE ORAL | *FELDENE 10 MG CAPSULE* |
| PIROXICAM 20MG CAPSULE ORAL | *FELDENE 20MG CAPSULE* |
| PREDNISONE TAB5 MG | *STERAPRED 5MG UNIPACK* |
| PREDNISONE TAB10 MG | *STERAPRED DS UNIPACK* |
| SALSALATE 500MG, 750MG CAPSULE/TABLET | *DISALCID CAPSULE/TABLET* |
| SULINDAC 150MG TABLET ORAL | *CLINORIL 150MG TABLET* |
| SULINDAC 200MG TABLET ORAL | *CLINORIL 200 MG TABLET* |
| TOLMETIN SODIUM 200MG TABLET ORAL | *TOLECTIN 200MG TABLET* |
| TOLMETIN SODIUM 400MG CAPSULE ORAL | *TOLECTIN DS 400MG CAPSULE* |
| TOLMETIN SODIUM 600MG TABLET ORAL | *TOLECTIN 600MG TABLET* |
| **SKELETAL MUSCLE RELAXANTS** | |
| **PREFERRED DRUG** | **Reference Trade Name** |
| BACLOFEN 10MG TABLET ORAL | *LIORESAL 10MG TABLET* |
| BACLOFEN 20MG TABLET ORAL | *LIORESAL 20MG TABLET* |
| CHLORZOXAZONE 250MG TABLET ORAL | *REMULAR-S 250MG TABLET* |
| CHLORZOXAZONE 500MG TABLET ORAL | *PARAFON FORTE DSC 500MG CAPSULE* |
| CYCLOBENZAPRINE HCL 10MG TABLET ORAL | *FLEXERIL 10 MG TABLET* |
| DIAZEPAM 5 MG TABLET ORAL | *VALIMUM 5 MG TABLET* |
| METHOCARBAMOL 500MG TABLET ORAL | *ROBAXIN 500 MG TABLET* |
| METHOCARBAMOL 750MG TABLET ORAL | *ROBAXIN-750 TABLET* |
| METHOCARBAMOL/ASPIRIN 400-325MG TABLET ORAL | *ROBAXISAL TABLET* |
| ORPHENADRINE CITRATE 100MG TABLET SA ORAL | *NORFLEX 100 MG TABLET SA* |
| ORPHENADRINE/ASPIRIN/CAFFEINE 25-385-30 TABLET ORAL | *NORGESIC TABLET* |
| ORPHENADRINE/ASPIRIN/CAFFEINE 50-770-60 TABLET ORAL | *NORGESIC FORTE TABLET* |
| TIZANIDINE HCL 2MG TABLET ORAL | *ZANAFLEX 2 MG TABLET* |
| TIZANIDINE HCL 4MG TABLET ORAL | *ZANAFLEX 4 MG TABLET* |
| **OPOID ANALGESICS** | |
| **PREFERRED DRUG** | **Reference Trade Name** |
| BUTORPHANOL TARTRATE 10MG/ML SPRAY NASAL | *STADOL NS 10MG/ML SPRAY* |
| CODEINE PHOS 15MG/5ML SOLUTION ORAL | *N/A* |
| CODEINE PHOS 30MG TABLET SOL ORAL | *N/A* |
| CODEINE PHOS 60MG TABLET SOL ORAL | *N/A* |
| CODEINE PHOS/ACETAMINOPHEN 12-120MG/5 ELIXIR ORAL | *TYLENOL W/CODEINE ELIXIR* |
| CODEINE PHOS/ACETAMINOPHEN 12-120MG/5 ORAL SUSP ORAL | *CAPITAL W/CODEINE ORAL SUSPENSION* |

| | |
|---|---|
| CODEINE PHOS/ACETAMINOPHEN 15-300MG TABLET ORAL | *TYLENOL W/CODEINE #2 TABLET* |
| CODEINE PHOS/ACETAMINOPHEN 30-300MG TABLET ORAL | *TYLENOL W/CODEINE #3 TABLET* |
| CODEINE PHOS/ACETAMINOPHEN 30-650MG TABLET ORAL | *PHENAPHEN-650 W/CODEINE TABLET* |
| CODEINE PHOS/ACETAMINOPHEN 60-300MG TABLET ORAL | *TYLENOL W/CODEINE #4 TABLET* |
| CODEINE PHOS/ASPIRIN 30-325MG TABLET ORAL | *EMPIRIN W/CODEINE 30MG TABLET* |
| CODEINE PHOS/ASPIRIN 60-325MG TABLET ORAL | *EMPIRIN W/CODEINE 60MG TABLET* |
| CODEINE SULF 15MG TABLET ORAL | *N/A* |
| CODEINE SULF 30MG TABLET ORAL | *N/A* |
| CODEINE SULF 60MG TABLET ORAL | *N/A* |
| CODEINE/APAP/CAFFEIN/BUTALB 30MG CAPSULE ORAL | *FIORICET W/CODEINE CAPSULE* |
| CODEINE/ASA/CAFFEINE/BUTALB 30MG CAPSULE ORAL | *FIORINAL/CODEINE #3 CAPSULE* |
| HYDROCODONE BIT/ACETAMINOPHEN 10-250MG TABLET ORAL | *STAGESIC-10 CAPLET* |
| HYDROCODONE BIT/ACETAMINOPHEN 10-325MG TABLET ORAL | *NORCO 10/325 TABLET* |
| HYDROCODONE BIT/ACETAMINOPHEN 10-500MG TABLET ORAL | *LORTAB 10/500 TABLET* |
| HYDROCODONE BIT/ACETAMINOPHEN 10-650MG TABLET ORAL | *LORCET 10/650 TABLET* |
| HYDROCODONE BIT/ACETAMINOPHEN 10-660MG TABLET ORAL | *VICODIN HP TABLET* |
| HYDROCODONE BIT/ACETAMINOPHEN 10-750MG TABLET ORAL | *MAXIDONE 10/750 MG TABLET* |
| HYDROCODONE BIT/ACETAMINOPHEN 2.5-167/5 ELIXIR ORAL | *LORTAB ELIXIR* |
| HYDROCODONE BIT/ACETAMINOPHEN 2.5-167/5 SOLUTION ORAL | *N/A* |
| HYDROCODONE BIT/ACETAMINOPHEN 2.5-500MG TABLET ORAL | *LORTAB 2.5/500 TABLET* |
| HYDROCODONE BIT/ACETAMINOPHEN 5-325MG TABLET ORAL | *NORCO 5/325 TABLET* |
| HYDROCODONE BIT/ACETAMINOPHEN 5-500MG CAPSULE ORAL | *LORCET HD CAPSULE* |
| HYDROCODONE BIT/ACETAMINOPHEN 5-500MG TABLET ORAL | *VICODIN 5/500 TABLET* |
| HYDROCODONE BIT/ACETAMINOPHEN 7.5-325MG TABLET ORAL | *NORCO 7.5/325 TABLET* |
| HYDROCODONE BIT/ACETAMINOPHEN 7.5-500MG TABLET ORAL | *LORTAB 7.5/500 TABLET* |
| HYDROCODONE BIT/ACETAMINOPHEN 7.5-650MG TABLET ORAL | *LORCET PLUS TABLET* |
| HYDROCODONE BIT/ACETAMINOPHEN 7.5-750MG TABLET ORAL | *VICODIN ES TABLET* |
| HYDROCODONE BIT/ASPIRIN 5-500MG TABLET ORAL | *LORTAB ASA TABLET* |
| HYDROMORPHONE HCL 1MG/ML LIQUID ORAL | *DILAUDID-5 1 MG/ML LIQUID* |
| HYDROMORPHONE HCL 2MG TABLET ORAL | *DILAUDID 2 MG TABLET* |

| | |
|---|---|
| HYDROMORPHONE HCL 4MG TABLET ORAL | *DILAUDID 4 MG TABLET* |
| HYDROMORPHONE HCL 8MG TABLET ORAL | *DILAUDID 8 MG TABLET* |
| IBUPROFEN/HYDROCODONE BIT 200-7.5MG TABLET ORAL | *VICOPROFEN TABLET* |
| MEPERIDINE HCL 100MG TABLET ORAL | *DEMEROL 100MG TABLET* |
| MEPERIDINE HCL 50MG TABLET ORAL | *DEMEROL 50 MG TABLET* |
| MEPERIDINE HCL 50MG/5ML SYRUP ORAL | *DEMEROL 50 MG/5 ML SYRUP* |
| MEPERIDINE HCL/PROMETH HCL 50-25MG CAPSULE ORAL | *MEPROZINE 50/25 CAPSULE* |
| METHADONE HCL 10MG TABLET ORAL | *DOLOPHINE HCL 10 MG TABLET* |
| **OPIOID ANALGESICS** | |
| **PREFERRED DRUG** | **Reference Trade Name** |
| METHADONE HCL 10MG/5ML SOLUTION ORAL | *N/A* |
| METHADONE HCL 10MG/ML ORAL CONC. ORAL | *METHADOSE 10 MG/ML ORAL CON* |
| METHADONE HCL 40MG TABLET SOL ORAL | *METHADOSE 40 MG TABLET DISP* |
| METHADONE HCL 5MG TABLET ORAL | *DOLOPHINE HCL 5 MG TABLET* |
| METHADONE HCL 5MG/5ML SOLUTION ORAL | *N/A* |
| MORPHINE SULFATE 10MG RECTAL SUPPOSITORY | *ROXANOL 10MG SUPPOSITORY* |
| MORPHINE SULFATE 10MG SOLUBLE TABLET | *N/A* |
| MORPHINE SULFATE 10MG/5ML SOLUTION ORAL | *MSIR 10 MG/5 ML ORAL SOLUTION* |
| MORPHINE SULFATE 15MG SOLUBLE TABLET | *N/A* |
| MORPHINE SULFATE 15MG TABLET ORAL | *MSIR 15MG TABLET* |
| MORPHINE SULFATE 20MG RECTAL SUPPOSITORY | *ROXANOL 20MG SUPPOSITORY* |
| MORPHINE SULFATE 20MG/5ML SOLUTION ORAL | *MSIR 20 MG/5 ML ORAL SOLUTION* |
| MORPHINE SULFATE 20MG/ML SOLUTION ORAL | *ROXANOL 20 MG/ML SOLUTION* |
| MORPHINE SULFATE 30MG RECTAL SUPPOSITORY | *ROXANOL 30MG SUPPOSITORY* |
| MORPHINE SULFATE 30MG SOLUBLE TABLET | *N/A* |
| MORPHINE SULFATE 30MG TABLET ORAL | *MSIR 30MG TABLET* |
| MORPHINE SULFATE 5MG RECTAL SUPPOSITORY | *ROXANOL 5MG SUPPOSITORY* |
| OXYCODONE HCL 15MG TABLET ORAL | *ROXICODONE 15 MG TABLET* |
| OXYCODONE HCL 20MG/ML ORAL CONC. ORAL | *OXYFAST 20 MG/ML SOLUTION* |
| OXYCODONE HCL 30MG TABLET ORAL | *ROXICODONE 30 MG TABLET* |
| OXYCODONE HCL 5MG CAPSULE ORAL | *OXYIR 5 MG CAPSULE* |
| OXYCODONE HCL 5MG TABLET ORAL | *ROXICODONE 5 MG TABLET* |
| OXYCODONE HCL 5MG/5ML SOLUTION ORAL | *ROXICODONE 5 MG/5 ML SOLUTION* |
| OXYCODONE HCL/ACETAMINOPHEN 10-325MG TABLET ORAL | *PERCOCET 10/325 MG TABLET* |
| OXYCODONE HCL/ACETAMINOPHEN 10-650MG TABLET ORAL | *PERCOCET 10/650 MG TABLET* |
| OXYCODONE HCL/ACETAMINOPHEN 2.5-325MG TABLET ORAL | *PERCOCET 2.5/325 MG TABLET* |
| OXYCODONE HCL/ACETAMINOPHEN 5-325/5ML SOLUTION ORAL | *ROXICET 5/325 ORAL SOLUTION* |
| OXYCODONE HCL/ACETAMINOPHEN 5-325MG TABLET ORAL | *PERCOCET 5/325 MG TABLET* |
| OXYCODONE HCL/ACETAMINOPHEN 5-500MG CAPSULE ORAL | *TYLOX 5/500 CAPSULE* |
| OXYCODONE HCL/ACETAMINOPHEN 7.5-325MG TABLET ORAL | *PERCOCET 7.5/325 MG TABLET* |

| | |
|---|---|
| OXYCODONE HCL/ACETAMINOPHEN 7.5-500MG TABLET ORAL | *PERCOCET 7.5/500 MG TABLET* |
| OXYCODONE/ASPIRIN 4.88-325MG TABLET ORAL | *PERCODAN TABLET* |
| OXYMORPHONE HCL 5MG RECTAL SUPPOSITORY | *NUMORPHAN 5 MG SUPPOSITORY* |
| PENTAZOCINE/ACETAMINOPHEN CAPLET | *TALACEN CAPLET* |
| PENTAZOCINE/NALOXONE TABLET | *TALWIN NX TABLET* |
| PROPOXYPHENE HCL 65MG CAPSULE ORAL | *DARVON 65 MG PULVULE* |
| PROPOXYPHENE HCL/ACETAMINOPHEN 65-650MG TABLET ORAL | *WYGESIC 65/650 TABLET* |
| PROPOXYPHENE HCL/ASA/CAFFEINE 32-389-32 CAPSULE ORAL | *DARVON COMPOUND-32 PULVULE* |
| PROPOXYPHENE HCL/ASA/CAFFEINE 65-389 CAPSULE ORAL | *DARVON COMPOUND-65 PULVULE* |
| PROPOXYPHENE NAPSYL 100MG TABLET ORAL | *DARVON-N 100 MG TABLET* |
| PROPOXYPHENE/ACETAMINOPHEN 100-325MG TABLET ORAL | *TRYCET 100/325 MG TABLET* |
| PROPOXYPHENE/ACETAMINOPHEN 100-650MG TABLET ORAL | *DARVOCET-N 100 TABLET* |
| PROPOXYPHENE/ACETAMINOPHEN 50-325MG TABLET ORAL | *DARVOCET-N 50 TABLET* |
| TRAMADOL HCL 50MG TABLET ORAL | *ULTRAM 50 MG TABLET* |
| TRAMADOL HCL/ACETAMINOPHEN 37.5-325MG TABLET ORAL | *ULTRACET TABLET* |
| **ADJUVANTS** | |
| **PREFERRED DRUG** | **Reference Trade Name** |
| AMITRIPTYLINE HCL 10MG, 25MG, 50MG, 75MG, 100MG | ELAVIL TABLETS |
| DESYREL TABLETS 50MG, 100MG | TAZADONE HCL |
| GABAPENTIN CAPSULES 100MG, 300MG, 400MG | NEURONTIN CAPSULES |
| NORTRIPTYLINE HCL CAPSULES 10MG, 25MG, 50MG, 75MG | PAMELOR CAPSULES |

**5.0 Utilization Review**

5.1 Pursuant to chapter 101, title 29 of the **Delaware Code**, the Department of Labor has developed a utilization review program with the intent of providing reference for employers, insurance carriers, and health care providers for evaluation of health care and charges. The intended purpose of utilization review services is to provide prompt resolution of issues related to treatment and/or compliance with the health care payment system or practice guidelines for those claims which have been acknowledged to be compensable.

5.2 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. Any person conducting a utilization review program for workers' compensation shall be required to register with the Office of Workers' Compensation once every two (2) years and certify compliance with Workers' Compensation Utilization Management Standards or Health Utilization Management Standards of Utilization Review Accreditation Council ("URAC") sufficient to achieve URAC accreditation or submit evidence of accreditation by URAC.

5.3 At this time, Utilization Review is limited to health care recommendations subject to practice guidelines developed by the HCAP.

5.4 An employer or insurance carrier may request utilization review by complying with all the terms and conditions set forth on the forms attached hereto. Upon completion and submission of the forms, information package and medical records package by the employer or insurance carrier, the designated utilization review company will review treatment to determine if it is in compliance with the

practice guidelines developed by the Health Care Advisory Panel and adopted and implemented by the Department of Labor. (See Appendix A) All past, prospective and concurrent health care decisions must be reviewed and a Utilization Review determination made no later than three (3) working days from receipt of the aforementioned information, for emergency care, but no later than 15 calendar days from the date of the treatment recommended by the physician or less if set forth in URAC guidelines.

5.5 If a party disagrees with the findings following utilization review, a petition may be filed with the Industrial Accident Board for *de novo* review.

5.6 If there are no current practice guidelines applicable to the health care provided, a party may file a petition with the Industrial Accident Board seeking a determination of the appropriateness of treatment.

## APPENDIX A

### DELAWARE DEPARTMENT OF LABOR
### MEDICAL UTILIZATION REVIEW PROGRAM

### REQUEST FOR UTILIZATION REVIEW
(Pursuant to 19 Del.C. §2322 F(j))

**PLEASE TYPE OR CLEARLY PRINT ALL INFORMATION.** All information and addresses must be verified as current and accurate.

1. Date of Request _____
2. WC Number(s) _____ Date(s) of injury _____
3. Nature of injury _____
4. Claimant's Name_____
   Age_____ Sex_____ Marital Status_____
   Address _____Tel No _____
   City _____State _____ Zip _____
   Attorney's Name_____
   Address _____Tel No _____
   City_____State _____ Zip _____

5. Employer_____ Occupation_____ Job Title_____
6. Party Requesting Review_____
   Primary Contact at Party's Office _____
   Address_____Tel No _____
   City _____ State _____ Zip_____

   Attorney's Name_____
   Address _____Tel No_____
   City _____State _____ Zip _____

7. Health Care Provider to be Reviewed_____
   Specialty (if applicable) _____
   Address_____Tel No_____
   City_____ State _____ Zip_____

8. Attach copies of all admissions and/or orders filed or entered in this case.

My signature certifies the following: a) all names and addresses on this form have been verified as current and accurate; b) seven identical copies of associated medical material are being submitted for review; and c) all items listed in the table of contents are in each copy of the medical material.

Print Name of Requester _____ Signature of Requester _____

**COPY THIS FORM OR REPRODUCE EXACTLY IN APPEARANCE AND CONTENT**
**SEE INSTRUCTIONS ON BACK**

Rev. _____ 1 of 2

## REQUIRED CONTENT, PRESENTATION AND BINDING METHOD FOR ALL MATERIALS SUBMITTED FOR UTILIZATION REVIEW

In accordance with **19 Del.C. §2322 F(j)** and the regulations adopted pursuant thereto, all information and medical records submitted to the Department of Labor, Office of Workers' Compensation must represent all of the facts of this case.

### INFORMATION PACKAGE - REQUIRED CONTENT

Completed and signed Request for Utilization Review Form.
A list containing the full names and medical specialties of all providers under review and individuals who performed defense medical examinations relevant to the matter under review.

### MEDICAL RECORDS PACKAGE - REQUIRED CONTENT

1. **Case Report** - The case report shall contain the following:
   a. Name, discipline of care and specialty of the Provider under review; date the provider first treated the claimant.
   b. Claimant's standard demographic information (age, sex, marital status, etc.).
   c. Claimant's employer and occupation/job title.
   d. Date(s) and nature of claimant's work-related injury/exposure.
   e. Date of initial treatment, a brief chronological history of treatment to the present date, and any significant contributing factors which may have had a direct effect on the length of treatment (e.g., diabetes).
   f. Treatment to be reviewed (specify each treatment modality to be reviewed).
2. **Table of Contents**
   Section 1. A copy of the Employer's First Report of Injury.
   Section 2. All reports, notes, etc., from provider being reviewed as submitted to the requesting party.
   Section 3. All reports, notes, etc., of other treating providers as submitted to the requesting party.
   Section 4. All reports resulting from referrals, consultations, DME's and second opinions as submitted to the requesting party.
   Section *5.* All diagnostic test results as submitted to the requesting party.
   Section 6. All medical management reports as submitted to the requesting party.
   Section 7. All hospital/clinic records related to the injury as submitted to the requesting party.

**NOTE** Do not include copies of any billing statements or comments/instructions directed to the Utilization Review panel. All material **must** be presented in identified sections; each section's content presented in chronological order.

### REQUIRED PRESENTATION AND BINDING METHOD FOR ALL SUBMITTED MATERIALS

INFORMATION PACKAGE - SUBMIT ONE COPY ONLY -- staple in upper-left-hand corner.
MEDICAL RECORDS PACKAGE - SUBMIT SEVEN (7) COPIES

a. All submitted material must be presented in seven (7) identical bound copies.
b. If tabs are used for the sections, they must be positioned to the right side of the document.

Mail or Deliver to: **Department of Labor**
Office of Workers' Compensation
4425 N. Market St.
P.O. Box 9954
Wilmington, DE 19809
**302-761-8200**