Fee Review FAQs

Q. If healthcare providers are not paid correctly or timely for services they rendered to an injured worker, what is their recourse?
A. The provider may file a fee review. Please refer to the Workers' Compensation Rules and Regulations, starting with Section 127.251.

Q. Are there time constraints for filing a fee review?
A. Yes. Per Section 127.252(a), a provider may file an application for fee review within 90 days from the original billing date of treatment, or 30 days from a notification of disputed treatment, whichever is later.

Q. Why must I submit a new fee review application with each resubmission?
A. Online applications for fee review that are returned with a fourteen-day file preservation date may be edited and resubmitted within fourteen days of the date of return. These applications become "new" fee review applications because when any changes are made to the fee review application, the proof of service must be updated. Providers should serve a copy of the resubmitted application and its documents upon the insurer.

Q. What is the LIBC-9?
A. The Medical Report Form, LIBC-9, is a form prescribed by the bureau. Section 127.203(a) of the regulations states: Providers who treat injured employees are required to submit periodic medical reports to the employer, commencing 10 days after treatment begins and at least once a month thereafter as long as treatment continues. If the employer is covered by an insurer, the provider shall submit the report to the insurer.

Also note: Section 127.203(d) states: If a provider does not submit the required medical reports on the prescribed form, the insurer is not obligated to pay for the treatment covered by the report until the required report is received by the insurer.

Q. Where can I obtain Medical Report (LIBC-9) and Application for Fee Review (LIBC-507) forms?
A. Visit our website to be directed to an interactive LIBC-9 form that you may complete, print or otherwise circulate. The Application for Fee Review (LIBC-507) may be completed on WCAIS. Please reference the Customer Service feature within WCAIS for filing instructions and simulations. For further assistance, you may email Healthcare Services at ra-li-bwc-hcsrd@pa.gov.

Q. As a provider, who do I bill?
A. You must first determine if the employer has workers' compensation coverage. Contact the employer and ask for the name of their insurance carrier. You may want to call the insurance carrier to verify the information the employer gave you is correct.

Sometimes insurance carriers or self-insured employers will use third party administrators (TPA) and you may be directed to send the bill to the TPA.

You can look up who an employer is insured by using the bureau's Workers' Compensation Search Form by visiting our website.

If you still are unable to determine who the correct insurer is, you may access WCAIS and in the Search Questions Repository of the Customer Service feature, you may click on the hyperlink for Submit a Ticket and ask for help from bureau staff. Additionally, you may email Healthcare Services at ra-li-bwc-hcsrd@pa.gov for assistance.

Q. If a provider does not agree with the decision they have received from the bureau, should they call the staff to discuss the decision?
A. No, the Healthcare Services Review Division cannot discuss any decision that it has issued. Providers may, however, appeal decisions as outlined in the decision letter.

Q. I have received a positive fee review decision but have not received my reimbursement. What can I do?
A. Follow your bad debt office policy to collect the debts owed to you.

Q. When should a provider expect reimbursement from an insurer?
A. Per Section 127.208(a), payments for treatments rendered under the act shall be made within 30 days of receipt of the bill and report (LIBC-9) submitted by the provider.

Q. Do Pennsylvania providers require pre-approval from the bureau on a claim?
A. There is no pre-authorization process in the Workers' Compensation Act. However, prospective utilization review on future treatment may be requested on behalf of the employer, insurer, or employee when questions arise about proposed treatment. Please refer to Section 127.404 of the regulations for more information.

Q. Can I balance-bill the patient?
A. No. Regulation 127.211(a) states: A provider may not hold an employe liable for costs related to care or services rendered in connection with a compensable injury under the act. A provider may not bill for, or otherwise attempt to recover from the employe, the difference between the provider's charge and the amount paid by an insurer.

Q. Will I be granted interest on untimely payments?
A. According to Regulation 127.210(a), if an insurer fails to pay the entire bill or any portion of a bill within 30 days of receipt of the required bills and medical reports, interest shall accrue on the due and unpaid balance at 10 percent per annum, under Section 406.1(a) of the act (77 P. S. § 717.1).

Additionally, Regulation 127.210(c) states: Interest shall accrue on unpaid medical bills even if an insurer initially denies liability, if liability is later admitted or determined.

Q. When does place of service apply?
A. Place of service only applies when:

- There is an amount listed in the place of service column; and
- A provider bills with place of service identified by CMS as subject to place of service differential: 19, 21, 22, 23, 24, 26, 31, 34, 41, 42, 51, 52, 53, 56, and 61.

If no amount is listed in the place of service column, reimbursement will be at the fee schedule amount.

Q. Is a copy of the workers' compensation medical fee schedule available?
A. With the exception of Table I, a courtesy copy of the current year's fee schedule is available on our website. To obtain Table I, or historical fee schedules, please contact our Chargemaster vendor, MM Associates, LLC by emailing mmassociatesllc@aol.com or calling 215-542-8780.