CHAPTER 290

An Act to amend and reenact §§ 2.2-4006, 65.2-605, 65.2-605.1, and 65.2-714 of the Code of Virginia; to amend the Code of Virginia by adding sections numbered 65.2-605.2 and 65.2-821.1; and to repeal Chapter 13 (§§ 65.2-1300 through 65.2-1310) of Title 65.2 of the Code of Virginia, relating to workers' compensation; fees for medical and legal services.

[S 631]

Approved March 7, 2016

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-4006, 65.2-605, 65.2-605.1, and 65.2-714 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding sections numbered 65.2-605.2 and 65.2-821.1 as follows:

§ 2.2-4006. Exemptions from requirements of this article.

A. The following agency actions otherwise subject to this chapter and § 2.2-4103 of the Virginia Register Act shall be exempted from the operation of this article:

1. Agency orders or regulations fixing rates or prices.

2. Regulations that establish or prescribe agency organization, internal practice or procedures, including delegations of authority.

3. Regulations that consist only of changes in style or form or corrections of technical errors. Each promulgating agency shall review all references to sections of the Code of Virginia within their regulations each time a new supplement or replacement volume to the Code of Virginia is published to ensure the accuracy of each section or section subdivision identification listed.

4. Regulations that are:

a. Necessary to conform to changes in Virginia statutory law or the appropriation act where no agency discretion is involved. However, such regulations shall be filed with the Registrar within 90 days of the law's effective date;

b. Required by order of any state or federal court of competent jurisdiction where no agency discretion is involved; or

c. Necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation, and the Registrar has so determined in writing. Notice of the proposed adoption of these regulations and the Registrar's determination shall be published in the Virginia Register not less than 30 days prior to the effective date of the regulation.

5. Regulations of the Board of Agriculture and Consumer Services adopted pursuant to subsection B of § 3.2-3929 or clause (v) or (vi) of subsection C of § 3.2-3931 after having been considered at two or more Board meetings and one public hearing.

6. Regulations of the regulatory boards served by (i) the Department of Labor and Industry pursuant to Title 40.1 and (ii) the Department of Professional and Occupational Regulation or the Department of Health Professions pursuant to Title 54.1 that are limited to reducing fees charged to regulants and applicants.

7. The development and issuance of procedural policy relating to risk-based mine inspections by the Department of Mines, Minerals and Energy authorized pursuant to §§ 45.1-161.82 and 45.1-161.292:55.

8. General permits issued by the (a) State Air Pollution Control Board pursuant to Chapter 13 (§ 10.1-1300 et seq.) of Title 10.1 or (b) State Water Control Board pursuant to the State Water Control Law (§ 62.1-44.2 et seq.), Chapter 24 (§ 62.1-242 et seq.) of Title 62.1 and Chapter 25 (§ 62.1-254 et seq.) of Title 62.1, (c) Virginia Soil and Water Conservation Board pursuant to the Dam Safety Act (§ 10.1-604 et seq.), and (d) the development and issuance of general wetlands permits by the Marine Resources Commission pursuant to subsection B of § 28.2-1307, if the respective Board or Commission (i) provides a Notice of Intended Regulatory Action in conformance with the provisions of § 2.2-4007.01, (ii) following the passage of 30 days from the publication of the Notice of Intended Regulatory Action forms a technical advisory committee composed of relevant stakeholders, including potentially affected citizens groups, to assist in the development of the general permit, (iii) provides notice and receives oral and written comment as provided in § 2.2-4007.03, and (iv) conducts at least one public hearing on the proposed general permit.

9. The development and issuance by the Board of Education of guidelines on constitutional rights and restrictions relating to the recitation of the pledge of allegiance to the American flag in public schools pursuant to § 22.1-202.

10. Regulations of the Board of the Virginia College Savings Plan adopted pursuant to § 23-38.77.

11. Regulations of the Marine Resources Commission.

12. Regulations adopted by the Board of Housing and Community Development pursuant to (i)

Statewide Fire Prevention Code (§ 27-94 et seq.), (ii) the Industrialized Building Safety Law (§ 36-70 et seq.), (iii) the Uniform Statewide Building Code (§ 36-97 et seq.), and (iv) § 36-98.3, provided the Board (a) provides a Notice of Intended Regulatory Action in conformance with the provisions of § 2.2-4007.01, (b) publishes the proposed regulation and provides an opportunity for oral and written comments as provided in § 2.2-4007.03, and (c) conducts at least one public hearing as provided in §§ 2.2-4009 and 36-100 prior to the publishing of the proposed regulations. Notwithstanding the provisions of this subdivision, any regulations promulgated by the Board shall remain subject to the provisions of § 2.2-4007.06 concerning public petitions, and §§ 2.2-4013 and 2.2-4014 concerning review by the Governor and General Assembly.

13. Amendments to the list of drugs susceptible to counterfeiting adopted by the Board of Pharmacy pursuant to subsection B of § 54.1-3307 or amendments to regulations of the Board to schedule a substance in Schedule I or II pursuant to subsection D of § 54.1-3443.

14. Waste load allocations adopted, amended, or repealed by the State Water Control Board pursuant to the State Water Control Law (§ 62.1-44.2 et seq.), including but not limited to Article 4.01 (§ 62.1-44.19:4 et seq.) of the State Water Control Law, if the Board (i) provides public notice in the Virginia Register; (ii) if requested by the public during the initial public notice 30-day comment period, forms an advisory group composed of relevant stakeholders; (iii) receives and provides summary response to written comments; and (iv) conducts at least one public meeting. Notwithstanding the provisions of this subdivision, any such waste load allocations adopted, amended, or repealed by the Board shall be subject to the provisions of §§ 2.2-4013 and 2.2-4014 concerning review by the Governor and General Assembly.

15. Regulations of the Workers' Compensation Commission adopted pursuant to § 65.2-605, including regulations that adopt, amend, adjust, or repeal Virginia fee schedules for medical services, provided the Workers' Compensation Commission (i) utilizes a regulatory advisory panel constituted as provided in subdivision F 2 of § 65.2-605 to assist in the development of such regulations and (ii) provides an opportunity for public comment on the regulations prior to adoption.

B. Whenever regulations are adopted under this section, the agency shall state as part thereof that it will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision. The effective date of regulations adopted under this section shall be in accordance with the provisions of § 2.2-4015, except in the case of emergency regulations, which shall become effective as provided in subsection B of § 2.2-4012.

C. A regulation for which an exemption is claimed under this section or § 2.2-4002 or 2.2-4011 and that is placed before a board or commission for consideration shall be provided at least two days in advance of the board or commission meeting to members of the public that request a copy of that regulation. A copy of that regulation shall be made available to the public attending such meeting.

§ 65.2-605. Liability of employer for medical services ordered by Commission; fee schedules for medical services; malpractice; assistants-at-surgery; coding.

A. *As used in this section, unless the context requires a different meaning:*

"Burn center" means a treatment facility designated as a burn center pursuant to the verification program jointly administered by the American Burn Association and the American College of Surgeons and verified by the Commonwealth.

"Categories of providers of fee scheduled medical services" means:

1. Physicians exclusive of surgeons;

2. Surgeons;

3. Type One teaching hospitals;

4. Hospitals, exclusive of Type One teaching hospitals;

5. Ambulatory surgical centers;

6. Providers of outpatient medical services not covered by subdivision 1, 2, or 5; and

7. Purveyors of miscellaneous items and any other providers not described in subdivisions 1 through 6, as established by the Commission in regulations adopted pursuant to subsection C.

"Codes" means, as applicable, CPT codes, HCPCS codes, or DRG classifications.

"CPT codes" means the medical and surgical identifying codes using the Physicians' Current Procedural Terminology published by the American Medical Association.

"Diagnosis related group" or "DRG" means the system of classifying in-patient hospital stays adopted for use with the Inpatient Prospective Payment System.

"Fee scheduled medical service" means a medical service exclusive of a medical service provided in the treatment of a traumatic injury or serious burn.

"Health Care Common Procedure Coding System codes" or "HCPCS codes" means the medical coding system used to report hospital outpatient and certain physician services as published by the National Uniform Billing Committee, including Temporary National Code (Non-Medicare) S0000-S-9999.

"Level I or Level II trauma center" means a hospital in the Commonwealth designated by the Board of Health as a Level I trauma center or a Level II trauma center pursuant to the Statewide Emergency Medical Services Plan developed in accordance with § 32.1-111.3.

"Medical community" means one of the following six regions of the Commonwealth:

1. Northern region, consisting of the area for which three-digit ZIP code prefixes 201 and 220 through 223 have been assigned by the U.S. Postal Service.

2. Northwest region, consisting of the area for which three-digit ZIP code prefixes 224 through 229 have been assigned by the U.S. Postal Service.

3. Central region, consisting of the area for which three-digit ZIP code prefixes 230, 231, 232, 238, and 239 have been assigned by the U.S. Postal Service.

4. Eastern region, consisting of the area for which three-digit ZIP code prefixes 233 through 237 have been assigned by the U.S. Postal Service.

5. Near Southwest region, consisting of the area for which three-digit ZIP code prefixes 240, 241, 244, and 245 have been assigned by the U.S. Postal Service.

6. Far Southwest region, consisting of the area for which three-digit ZIP code prefixes 242, 243, and 246 have been assigned by the U.S. Postal Service.

"Medical service" means any medical, surgical, or hospital service required to be provided to an injured person pursuant to this title.

"Miscellaneous items" means medical services provided under this title that are not included within subdivisions 1 through 6 of the definition of categories of providers of fee scheduled medical services. "Miscellaneous items" does not include (i) pharmaceuticals that are dispensed by providers, other than hospitals or Type One teaching hospitals as part of inpatient or outpatient medical services, or dispensed as part of fee scheduled medical services at an ambulatory surgical center or (ii) durable medical equipment dispensed at retail.

"Physician" means a person licensed to practice medicine or osteopathy in the Commonwealth pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1.

"Provider" means a person licensed by the Commonwealth to provide a medical service to a claimant under this title.

"Reimbursement objective" means the average of all reimbursements and other amounts paid to providers in the same category of providers of fee scheduled medical services in the same medical community for providing a fee scheduled medical service to a claimant under this title during the most recent period preceding the transition date for which statistically reliable data is available as determined by the Commission.

"Serious burn" means a burn for which admission or transfer to a burn center is medically necessary.

"Transition date" means the date the regulations of the Commission adopting initial Virginia fee schedules for medical services pursuant to subsection C become effective.

"Traumatic injury" means an injury for which admission or transfer to a Level I or Level II trauma center is medically necessary and that is assigned a DRG number of 003, 004, 011, 012, 013, 025 through 029, 082, 085, 453, 454, 455, 459, 460, 463, 464, 465, 474, 475, 483, 500, 507, 510, 515, 516, 570, 856, 857, 862, 901, 904, 907, 908, 955 through 959, 963, 998, or 999. Claimants who die in an emergency room of trauma or burn before admission shall be deemed to be claimants who incurred a traumatic injury.

"Type One teaching hospital" means a hospital that was a state-owned teaching hospital on January 1, 1996.

"Virginia fee schedule" means a schedule of maximum fees for fee scheduled medical services for the medical community where the fee scheduled medical service is provided, as initially adopted by the Commission pursuant to subsection C and as adjusted as provided in subsection D.

B. The pecuniary liability of the employer for ~~medical~~ *a:*

1. Medical, surgical, and hospital service herein required when ordered by the Commission *that is provided to an injured person prior to the transition date, regardless of the date of injury,* shall be limited *absent a contract providing otherwise,* to such charges as prevail in the same community for similar treatment when such treatment is paid for by the injured person ~~and the~~*;*

2. Fee scheduled medical service provided on or after the transition date, regardless of the date of injury, shall be limited to:

a. The amount provided for the payment for the fee scheduled medical service as set forth in a contract under which the provider has agreed to accept a specified amount in payment for the service provided, which amount may be less than or exceed the maximum amount for the service as set forth in the applicable Virginia fee schedule;

b. In the absence of a contract described in subdivision 2 a, the lesser of the billing amount or the amount for the fee scheduled medical service as set forth in the applicable Virginia fee schedule that is in effect on the date the service is provided, subject to an increase approved by the Commission pursuant to subsection H; or

c. In the absence of (i) a contract described in subdivision 2 a and (ii) a provision in a Virginia fee schedule that sets forth a maximum amount for the medical service on the date it is provided, the maximum amount determined by the Commission as provided in subsection E; and

3. Medical service provided on or after the transition date in the treatment of a traumatic injury or

serious burn, regardless of the date of injury, shall be limited to:

a. The amount provided for the payment for the medical service provided for the treatment of the traumatic injury or serious burn as set forth in a contract under which the provider has agreed to accept a specified amount in payment for the service provided, which amount may be less than or exceed the maximum amount for the service calculated pursuant to subdivision 3 b; or

b. In the absence of a contract described in subdivision 3 a, an amount equal to 80 percent of the provider's charge for the service based on the provider's charge master or schedule of fees; however, if the compensability under this title of a claim for traumatic injury or serious burn is contested and after a hearing on the claim on its merits or after abandonment of a defense by the employer or insurance carrier, benefits for medical services are awarded and inure to the benefit of a third-party insurance carrier or health care provider and the Commission awards to the claimant's attorney a fee pursuant to subsection B of § 65.2-714, then the pecuniary liability of the employer for the service provided shall be limited to 100 percent of the provider's charge for the service based on the provider's charge master or schedule of fees.

C. The Commission shall adopt regulations establishing initial Virginia fee schedules for fee scheduled medical services as follows:

1. The Commission's regulations that establish the initial Virginia fee schedules shall be effective on January 1, 2018.

2. Separate initial Virginia fee schedules shall be established for fee scheduled medical services (i) provided by each category of providers of fee scheduled medical services and (ii) within each of the medical communities to reflect the variations among the medical communities as provided in subdivision 3, for each category of providers of fee scheduled medical services.

3. The Virginia fee schedules for each medical community shall reflect variations among medical communities in (i) all reimbursements and other amounts paid to providers for fee scheduled medical services among the medical communities and (ii) the extent to which the number of providers within the various medical communities is adequate to meet the needs of injured workers.

4. In establishing the initial Virginia fee schedules for fee scheduled medical services, the Commission shall establish the maximum fee for each fee scheduled medical service at a level that approximates the reimbursement objective for each category of providers of fee scheduled medical services among the medical communities. The Commission shall retain a firm with nationwide experience and actuarial expertise in the development of workers' compensation fee schedules to assist the Commission in establishing the initial Virginia fee schedules. The Commission shall consult with the regulatory advisory panel established pursuant to subdivision F 2 prior to retaining such firm. Such firm shall be retained to assist the Commission in developing the Virginia fee schedules by recommending a methodology that will provide, at reasonable cost to the Commission, statistically valid estimates of the reimbursement objective for fee scheduled medical services within the medical communities, based on available data or, if the necessary data is not available, by recommending the optimal methodology for obtaining the necessary data. The Commission shall consult with the regulatory advisory panel prior to adopting any such methodology. Such methodology may, but is not required to, be based on applicable codes. The estimates of the reimbursement objective for fee scheduled medical services shall be derived from data on all reimbursements and other amounts paid to providers for fee scheduled medical services provided pursuant to this title during 2014 and 2015, to the extent available.

D. The Commission shall review Virginia fee schedules during the year that follows the transition date and biennially thereafter and, if necessary, adjust the Virginia fee schedules in order to address (i) inflation or deflation as reflected in the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) for the South as published by the Bureau of Labor Statistics of the U.S. Department of Labor; (ii) access to fee scheduled medical services; (iii) errors in calculations made in preparing the Virginia fee schedules; and (iv) incentives for providers. The Commission shall not adjust a Virginia fee schedule in a manner that reduces fees on an existing schedule unless such a reduction is based on deflation or a finding by the Commission that advances in technology or errors in calculations made in preparing the Virginia fee schedules justify a reduction in fees.

E. The maximum pecuniary liability of the employer for a fee scheduled medical service that is not included in a Virginia fee schedule when it is provided shall be determined by the Commission. The Commission's determination of the employer's maximum pecuniary liability for such fee scheduled medical service shall be effective until the Commission sets a maximum fee for the fee scheduled medical service and incorporates such maximum fee into an adjusted Virginia fee schedule adopted pursuant to subsection D. If the fee scheduled medical service is not included in a Virginia fee schedule because it is:

1. A new type of technology, including an implantable medical device or item of medical equipment, that is supplied by a third party, provided that such technology has been cleared or approved by the federal Food and Drug Administration (FDA) prior to the date of the provision of the medical service, the employer's maximum pecuniary liability shall not exceed 130 percent of the provider's invoiced cost for such device, as evidenced by a copy of the invoice. If the new type of technology has not been cleared or approved by the FDA prior to such date, then the provider shall not be entitled to payment

or reimbursement therefor unless the employer or its insurer agree; or

2. A new type of procedure that has not been assigned a billing code, the employer's maximum pecuniary liability shall not exceed 80 percent of the provider's charge for the service based on the provider's charge master or schedule of fees, provided the employer and the provider mutually agree to the provision of such procedure.

F. The Commission shall:

1. Provide public access to information regarding the Virginia fee schedules for medical services, by categories of providers of fee scheduled medical services and for each medical community, through the Commission's website. No information provided on the website shall be provider-specific or disclose or release the identity of any provider; and

2. Utilize a 10-member regulatory advisory panel to assist in the development of regulations adopting initial Virginia fee schedules pursuant to subsection C and in adjusting initial Virginia fee schedules pursuant to subsection D. One member of the regulatory advisory panel shall be selected by the Commission from each of the following: (i) the American Insurance Association; (ii) the Property and Casualty Insurers Association of America; (iii) the Virginia Self-Insurers Association, Inc.; (iv) the Medical Society of Virginia; (v) the Virginia Hospital and Healthcare Association; (vi) a Type One teaching hospital; (vii) the Virginia Orthopaedic Society; (viii) the Virginia Trial Lawyers Association; (ix) a group self-insurance association representing employers; and (x) a local government group self-insurance pool formed under Chapter 27 (§ 15.2-2700 et seq.) of Title 15.2. The Commission shall meet with the regulatory advisory panel and consider the recommendations of its members in its development of the Virginia fee schedules pursuant to subsections C and D.

G. The Commission's retaining of a firm with nationwide experience and actuarial expertise in the development of workers' compensation fee schedules to assist the Commission in developing the Virginia fee schedules pursuant to subsections C and D shall be exempt from the provisions of the Virginia Public Procurement Act (§ 2.2-4300 et seq.), provided the Commission shall issue a request for proposals that requires submission by a bidder of evidence that it satisfies the conditions for eligibility established in this subsection and in subdivision C 4. Records and information relating to payments or reimbursements to providers that is obtained by or furnished to the Commission by such firm or any other person shall (i) be for the exclusive use of the Commission in the course of the Commission's development of fee schedules and related regulations and (ii) shall remain confidential and shall not be subject to the provisions of the Virginia Freedom of Information Act (§ 2.2-3700 et seq.).

H. When the total charges of a hospital or Type One teaching hospital, based on such provider's charge master, for inpatient hospital services covered by a DRG code exceed the charge outlier threshold, then the Commission shall establish the maximum fee for such scheduled inpatient hospital services at an amount equal to the total of (i) the maximum fee for the service as set forth in the applicable fee schedule and (ii) 80 percent of the provider's total charges for the service in excess of the charge outlier threshold. The charge outlier threshold for such services initially shall equal 150 percent of the maximum fee for the service set forth in the applicable fee schedule; however, the Commission, in consultation with the firm retained pursuant to subdivision C 4, is authorized on a biennial basis to decrease such percentage if it finds that the number of such claims for which the total charges of the hospital or Type One teaching hospital exceed the charge outlier threshold is less than five percent or to increase such percentage if such number is greater than 10 percent of all such claims.

I. No provider shall use a different charge master or schedule of fees for any medical service provided under this title than the provider uses for health care services provided to patients who are not claimants under this title.

J. The employer shall not be liable in damages for malpractice by a physician or surgeon furnished by him pursuant to the provisions of § 65.2-603, but the consequences of any such malpractice shall be deemed part of the injury resulting from the accident and shall be compensated for as such.

~~B.~~ *K.* The Commission shall determine the number and geographic area of communities across the Commonwealth. In establishing the communities, the Commission shall consider the ability to obtain relevant ~~charge~~ data based on geographic area and such other criteria as are consistent with the purposes of this title. *The Commission shall use the communities established pursuant to this subsection in determining charges that prevail in the same community for treatment provided prior to the transition date.*

~~C.~~ *L.* The pecuniary liability of the employer for treatment ~~pursuant to subsection A~~ *of a medical service* that is rendered on or after July 1, 2014, by:

1. A nurse practitioner or physician assistant serving as an assistant-at-surgery shall be limited to no more than 20 percent of the reimbursement due ~~under subsection A~~ to the physician performing the surgery; and

2. An assistant surgeon in the same specialty as the primary surgeon shall be limited to no more than 50 percent of the reimbursement due ~~under subsection A~~ to the primary physician performing the surgery.

~~D.~~ *M.* Multiple procedures completed on a single surgical site associated with *a* medical~~, surgical, and hospital services pursuant to subsection A and~~ *service* rendered on or after July 1, 2014, shall be

coded and billed with appropriate ~~Current Procedural Terminology (~~CPT~~)~~ *codes and* modifiers and paid according to the National Correct Coding Initiative ~~(~~NCCI~~)~~ rules and the CPT *codes* as in effect at the time the health care was provided to the claimant.

N. The CPT *code* and ~~NCCI~~ *National Correct Coding Initiative rules*, as in effect at the time ~~such health care~~ *a medical service* was provided to the claimant, shall serve as the basis for processing a health care provider's billing form or itemization for such items as global and comprehensive billing and the unbundling of ~~health care~~ *medical* services. Hospital in-patient ~~health care~~ *medical* services shall be coded and billed through the International Statistical Classification of Diseases and Related Health Problems ~~(ICD)~~ as in effect at the time the ~~health care~~ *medical service* was provided to the claimant.

§ 65.2-605.1. Prompt payment; limitation on claims.

A. Payment for health care services that the employer does not contest, deny, or consider incomplete shall be made to the health care provider within 60 days after receipt of each separate itemization of the health care services provided.

B. If the itemization or a portion thereof is contested, denied, or considered incomplete, the employer or the employer's workers' compensation insurance carrier shall notify the health care provider within 45 days after receipt of the itemization that the itemization is contested, denied, or considered incomplete. The notification shall include the following information:

1. The reasons for contesting or denying the itemization, or the reasons the itemization is considered incomplete;

2. If the itemization is considered incomplete, all additional information required to make a decision; and

3. The remedies available to the health care provider if the health care provider disagrees.

Payment or denial shall be made within 60 days after receipt from the health care provider of the information requested by the employer or employer's workers' compensation carrier for an incomplete claim under this subsection.

C. Payment due for any properly documented health care services that are neither contested within the 45-day period nor paid within the 60-day period, as required by this section, shall be increased by interest at the judgment rate of interest as provided in § 6.2-302 retroactive to the date payment was due under this section.

D. An employer's liability to a health care provider under this section shall not affect its liability to an employee.

E. No employer or workers' compensation carrier may seek recovery of a payment made to a health care provider for health care services rendered after July 1, 2014, to a claimant, unless such recovery is sought less than one year from the date payment was made to the health care provider, except in cases of fraud. The Commission shall have jurisdiction over any disputes over recoveries.

F. No health care provider shall submit a claim to the Commission contesting the sufficiency of payment for health care services rendered to a claimant after July 1, 2014, unless (i) such claim is filed within one year of the date the last payment is received by the health care provider pursuant to this section or (ii) if the employer denied or contested payment for any portion of the health care services, then, as to that service or portion thereof, such claim is filed within one year of the date the medical award covering such date of service for a specific item or treatment in question becomes final.

G. Any health care provider located outside of the Commonwealth who provides health care services under the Act to a claimant shall be reimbursed as provided in this section, and the "same community," as used in ~~subsection A~~ *subdivision B 1* of § 65.2-605 *for treatment provided prior to the transition date as defined in subsection A of § 65.2-605*, shall be deemed to be the principal place of business of the employer if located in the Commonwealth or, if no such location exists, then the location where the Commission hearing regarding the dispute is conducted.

H. The Commission, by January 1, 2016, shall establish a schedule pursuant to which employers, employers' workers' compensation insurance carriers, and providers of workers' compensation medical services shall be required, by a date determined by the Commission that is no earlier than July 1, 2016, and no later than December 31, 2018, to adopt and implement infrastructure under which (i) providers of workers' compensation medical services (providers) shall submit their billing, claims, case management, health records, and all supporting documentation electronically to employers or employers' workers' compensation insurance carriers, as applicable (payers) and (ii) payers shall return actual payment, claim status, and remittance information electronically to providers that submit their billing and required supporting documentation electronically. The Commission shall establish standards and methods for such electronic submissions and transactions that are consistent with International Association of Industrial Accident Boards and Commission Medical Billing and Payment guidelines. The Commission shall determine the date by which payers and providers shall be required to adopt and implement the infrastructure, which determinations shall be based on the volume and complexity of workers' compensation cases in which the payer or provider is involved, the resources of the payer or provider, and such other criteria as the Commission determines to be appropriate.

§ 65.2-605.2. Biennial peer-reviewed studies.

A. The Commission shall have a peer-reviewed study conducted every two years commencing in 2016

by a reputable independent, not-for-profit research organization to determine how Virginia's workers' compensation system and workers' compensation medical costs compare with (i) those of other states' systems and (ii) previous workers' compensation medical benchmarks studies conducted in Virginia. Such studies shall also review the status of access to medical services under Virginia's workers' compensation system.

B. The Commission shall pay for the studies conducted pursuant to subsection A through revenues generated pursuant to the administrative tax assessed pursuant to Chapter 10 (§ 65.2-1000 et seq.) and deposited in the fund established pursuant to § 65.2-1007.

§ 65.2-714. Fees of attorneys and physicians and hospital charges.

A. Fees of attorneys and physicians and charges of hospitals for services, whether employed by employer, employee, or insurance carrier under this title, shall be subject to the approval and award of the Commission. ~~In addition to the provisions of Chapter 13 (§ 65.2-1300 et seq.), the~~ *The* Commission shall have exclusive jurisdiction over all disputes concerning such fees or charges and may order the repayment of the amount of any fee which has already been paid that it determines to be excessive; appeals from any Commission determinations thereon shall be taken as provided in § 65.2-706. The Commission shall also retain jurisdiction for employees to pursue payment of charges for medical services notwithstanding that bills or parts of bills for health care services may have been paid by a source other than an employer, workers' compensation carrier, guaranty fund, or uninsured employer's fund. No physician shall be entitled to collect fees from an employer or insurance carrier until he has made the reports required by the Commission in connection with the case.

B. If a contested claim is held to be compensable under this title and, after a hearing on the claim on its merits or after abandonment of a defense by the employer or insurance carrier, benefits for medical services are awarded and inure to the benefit of a ~~third party~~ *third-party* insurance carrier or health care provider, the Commission shall award to the employee's attorney a reasonable fee and other reasonable pro rata costs as are appropriate. *However, the Commission shall not award attorney fees under this subsection unless and until the employee's attorney has complied with Rule 6.2 of the Rules of the Commission. The fee shall be paid* from the sum ~~which~~ *that* benefits the ~~third party~~ *third-party* insurance carrier or health care provider. ~~Such fees shall be based on~~ *In determining whether the employee's attorney's work with regard to the contested claim resulted in an award of benefits that inure to the benefit of a third-party insurance carrier or health care provider, and in determining the reasonableness of the amount of any fee awarded to an attorney under this subsection, the Commission shall consider only* the amount paid by the employer or insurance carrier to the ~~third party~~ *third-party* insurance carrier or health care provider for medical, surgical, and hospital service rendered to the employee through *(i)* the date on which the contested claim is heard before the Deputy Commissioner*, is settled, or is resolved by order of the Commission or (ii) the date the employer or insurance carrier provides written notice of its abandonment of its defense to the contested claim and shall not consider additional amounts previously paid to a health care provider or reimbursed to a third-party insurance carrier*. For the purpose of this subsection, a "contested claim" is an initial contested claim for benefits and claims for medical, surgical, and hospital services that are subsequently contested and litigated or after abandonment of a defense by the employer or insurance carrier.

C. Payment of any obligation pursuant to this section to any ~~third party~~ *third-party* insurance carrier or health care provider shall discharge the obligation in full. The Commission shall not reduce the amount of medical bills owed to the Commonwealth or its agencies without the written consent of the Office of the Attorney General.

D. No physician, hospital, or other health care provider as defined in § 8.01-581.1 shall balance bill an employee in connection with any medical treatment, services, appliances, or supplies furnished to the employee in connection with an injury for which (i) a claim has been filed with the Commission pursuant to § 65.2-601, (ii) payment has been made to the health care provider pursuant to § 65.2-605.1, or (iii) an award of compensation is made pursuant to § 65.2-704. For the purpose of this subsection, a health care provider "balance bills" whenever (a) an employer or the employer's insurance carrier declines to pay all of the health care provider's charge or fee and (b) the health care provider seeks payment of the balance from the employee. Nothing in this section shall prohibit a health care provider from using the practices permitted in § 65.2-601.1.

§ 65.2-821.1. Payment and reimbursement practices; prohibitions.

A. As used in this section, unless the context requires a different meaning:

"Contracting entity" means (i) a person that enters into a provider contract with a provider or (ii) an intended beneficiary of the rights of such person under the provider contract.

"Employer" means the employer; any insurance carrier, group self-insured association, or other person providing coverage for the employer's obligation to provide medical service to a claimant under this title; or any third-party administrator acting on behalf of the employer.

"PPO network" means the multiple provider contracts available to an employer pursuant to a PPO network arrangement.

"PPO network arrangement" means an arrangement under which the PPO network arranger sells, conveys, or otherwise transfers to an employer the ability to discount payments or reimbursements to a

provider pursuant to the terms of multiple provider contracts to which the PPO network arranger is a direct party.

"PPO network arranger" means a person that operates a PPO network arrangement.

"Provider," "transition date," and "Virginia fee schedule" have the meaning assigned thereto in § 65.2-605. "Provider" includes a provider's employer or professional business entity.

"Provider contract" means an agreement between a contracting entity and a provider pursuant to which the provider agrees to deliver medical services to a claimant under this title in exchange for payment or reimbursement of an agreed-upon amount.

"Third-party administrator" means a person that administers, processes, handles, or pays claims to providers on behalf of an employer.

B. On and after the transition date:

1. No employer shall pay or reimburse a provider for medical services provided to a claimant less than the amount provided for in the applicable Virginia fee schedule or other amount determined as provided in subdivision B 2 or 3 of § 65.2-605 unless:

a. The employer has directly entered into:

(1) A provider contract with the provider;

(2) A contract with a contracting entity that has entered into a provider contract with the provider; or

(3) A contract with a PPO network arranger that authorizes the employer to use a PPO network to derive a benefit from a provider contract; and

b. The provider has agreed to provide medical services to the claimant for an agreed-upon reimbursement or contractual amount as set forth in a provider contract referenced in subdivision a.

2. A person with whom an employer has directly contracted as described in subdivision 1 a shall not sell, lease, or otherwise disseminate data regarding the payment or reimbursement amounts or terms of a provider contract without the express written consent and prior notification of all parties to the provider contract; however, the express written request from, and prior notification to, a provider shall not be required if the provider's identity has been redacted from such data.

3. If an employer uses or relies on a contract described in subdivision 1 a to discount a payment or reimbursement to a provider, the employer shall notify the provider, at the time it remits the payment or reimbursement, of (i) the name of the provider, contracting entity, or PPO network arranger with whom the employer directly contracted and (ii) how, if other than by a direct contract between the employer and the provider, the employer acquired the right to discount the payment or reimbursement to the provider.

4. If an employer uses or relies on a contract with a PPO network arranger described in subdivision 1 a (3) to discount a payment or reimbursement to a provider, the employer shall not shop for the lowest discount for a specific provider among the provider contracts held in multiple PPO networks. This prohibition shall not bar an employer that has entered into a PPO network arrangement and selected a provider contract in the PPO network from availing itself of all discounts provided pursuant to the selected provider contract in the PPO network.

C. Any person who suffers loss as a result of a violation of this section shall be entitled to initiate an action at the Commission to recover actual damages and interest from the date of the violation until entry of the final award. If the Commission finds that the violation resulted from gross negligence or willful misconduct, it may increase damages to an amount not to exceed three times the actual damages.

2. That the Workers' Compensation Commission's adoption of regulations establishing initial Virginia fee schedules for medical services pursuant to subsection C, and its adoption of regulations adjusting Virginia fee schedules for medical services pursuant to subsection D, of § 65.2-605 of the Code of Virginia as amended and reenacted by this act shall be exempt from the provisions of Article 2 (§ 2.2-4006 et seq.) of the Administrative Process Act (§ 2.2-4000 et seq.) of the Code of Virginia, provided that the Workers' Compensation Commission utilizes a regulatory advisory panel constituted as provided in subdivision F 2 of § 65.2-605 as added by this act to assist in the development of such regulations and provides an opportunity for public comment on the regulations prior to adoption.

3. That Chapter 13 (§§ 65.2-1300 through 65.2-1310) of Title 65.2 of the Code of Virginia is repealed.

4. That the Workers' Compensation Commission (Commission) shall select the members of the regulatory advisory panel created pursuant to subdivision F 2 of § 65.2-605 of the Code of Virginia as added by this act prior to August 1, 2016. The regulatory advisory panel shall meet, review, and make recommendations to the Commission prior to July 1, 2017, on workers' compensation issues relating to (i) pharmaceutical costs not previously included in the Virginia fee schedules; (ii) durable medical equipment costs not previously included in the Virginia fee schedules; (iii) attorney fees awarded under § 65.2-714; (iv) how to resolve the issues that the peer review committees established under Chapter 13 (§§ 65.2-1300 through 65.2-1310) of Title 65.2 of the Code of Virginia as repealed by this act had been authorized to address; (v) prior authorization for medical services; and (vi) any other issues that the Commission assigns to the

regulatory advisory panel.
5. That an emergency exists and this act is in force from its passage.