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HOUSE BILL NO. 2206

Offered January 10, 2013

A BILL to amend and reenact §§ 65.2-605 and 65.2-714 of the Code of Virginia and to amend the Code of Virginia by adding sections numbered 65.2-605.1 and 65.2-605.2, relating to the Virginia Workers' Compensation Act; payment of charges for medical services; duties of insurance carriers; unfair claim settlement practices; fees.

Patrons—Ware, R.L. and O'Bannon

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 65.2-605 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 65.2-605.1 and 65.2-605.2 as follows:

§ 65.2-605. Liability of employer for medical services ordered by Commission; malpractice.

A. The pecuniary liability of the employer for medical, surgical, and hospital service herein required when ordered by the Commission shall be ~~limited to such charges as prevail in the same community for similar treatment when such treatment is paid for by the injured person and 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.~~ *established as follows:*

1. Providers desiring to treat injured workers' compensation employees shall attempt reasonable steps to enter into one or more agreements with any one or more employers, workers' compensation insurance carriers, third-party administrators, and preferred provider organizations for provision of treatment of any covered employee. Such agreements shall establish rates for payment for treatment. Rates shall be negotiated in any such agreement between (i) provider and employer, (ii) provider and insurance carrier, (iii) provider and third-party administrator, or (iv) provider and preferred provider organization. Insurance carriers and employers entering into such agreements shall not change rates established in agreements through repricing, recoding, subcontracting, or other means; or

2. If there is no such agreement, then the provider and the insurance carrier or employer may negotiate a reasonable rate for a single episode of care; or

3. If a negotiated rate is not agreed upon pursuant to subdivision 1 or 2, the provider, insurance carrier, or employer may have its case heard by the Commission. In such event, the Commission shall determine the payment rate, which shall be limited to such charges as prevail in the same community for similar treatment when such treatment is paid for by the injured person, and 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. For health care services or treatment rendered after July 1, 2013, to a claimant, a health care provider shall be allowed to adjust the charge for provider fees, excluding implants, devices, or technology, by an amount that is less than or equal to the medical care component of the Consumer Price Index as published by the Bureau of Labor Statistics of the U.S. Department of Labor for the 12-month period preceding the date of the adjustment. An employer or carrier shall have no pecuniary liability for that portion of the provider fee that exceeds the adjustment of charges permitted by this subdivision.

B. Employers and insurance carriers shall provide employee access to an adequate network of health care providers.

C. The prompt payment provisions of § 65.2-605.1 and terms and conditions of § 65.2-605.2 shall apply to the payment of claims.

D. For health care services rendered after July 1, 2013, if an insurance carrier or employer files notices of denial of payment with the Commission for any bill or part of a bill for health care services and sends a copy of such notice to (i) the claimant, (ii) the attorney representing the claimant, and (iii) the health care provider, which notice is substantially in the following format, then any action brought to recover such denied fees and charges shall be forever barred unless filed with the Commission within two years from the date of receipt of such notice of denial:

"Notice to employee and health care provider:

Be advised that the workers' compensation insurance carrier or employer has denied payment for health care services rendered by the health care provider for the date or dates of services listed below and that you will have two years from your receipt of this notice to contest that denial by filing a claim for payment of such charges or risk having that claim barred.

Claimant_____
Attorney for Claimant_____
Health Care Provider _____
Dates of Service _____"

Notwithstanding any other provision of this subsection, when partial payment or less than full payment has been made on a bill or part thereof pursuant to an award order relating to that specific bill or part thereof, any claim to contest the sufficiency of payment related to such bill or part thereof shall be unenforceable if not filed within two years from the date partial payment was received by the health care provider. The Commission shall hear such claims on the record.

§ 65.2-605.1. Prompt payment.

A. Employers and employers' insurance carriers shall:

1. Make available all billing and reimbursement requirements, together with applicable documentation, to health care providers or make the same available via the Internet in real time;

2. Enable health care providers to electronically verify if a claim has been reported by an employee or employer;

3. Accept reports from health care providers electronically; and

4. Accept claims from health care providers electronically.

For the purposes of this section, "employers and employers' insurance carriers" includes the uninsured employer's fund and any guaranty fund.

B. Except as provided in provider agreements with employers or employers' insurance carriers, payment for health care services shall be made to the health care provider within 40 days after receipt of each separate itemization of the health care services provided. If the itemization or a portion thereof is contested, denied, or considered incomplete, the employer or the employer's insurance carrier shall notify the health care provider within 30 days after receipt of the itemization that the itemization is contested, denied, or considered incomplete and 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 due for any properly documented health care services that are neither contested within the 30-day period nor paid within the 40-day period, as required by this subsection, shall be increased by 15 percent, together with interest at the judgment rate of interest as provided in § 6.2-302 retroactive to the date of receipt of the itemization.

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

D. If the employer is a governmental entity, payment for health care services provided shall be made within 60 days after receipt of each separate itemization, together with all required reports.

E. In the absence of a provider agreement, whenever an employer or insurance carrier conducts an audit of an itemization submitted by a health care provider, the employer or employer's insurance carrier shall make available to that individual or entity all documentation submitted together with that itemization by the health care provider. No audit shall include an onsite visit to the office of the health care provider unless such auditor or reviewer reimburses the health care provider the actual cost of having staff present to participate in the audit or review. When an audit determines that additional information or documentation is necessary, the individual or entity shall contact the claims administrator or insurer to obtain the necessary information or documentation that was submitted by the health care provider pursuant to subsection B.

F. In the absence of a provider agreement, an audit of service submitted by a health care provider shall not alter the procedure codes listed. If the auditor does not recommend payment for services as itemized by the health care provider, a specific explanation of review shall be provided to the health care provider. No claim shall be audited later than one year from the date of service or date of payment, whichever is later.

G. The Commission shall have jurisdiction over disputes arising out of this section.

§ 65.2-605.2. Terms of agreements between health care providers and employers' insurance carriers.

A. As used in this section:

"Claim" means any bill, claim, or proof of loss made by or on behalf of a provider to a carrier with which the provider has a provider agreement for payment for health care services; however, "claim" does not include a request for payment of a capitation or a withhold.

"Health care services" means medical, surgical, and hospital services that an employer is required to provide to an injured person pursuant to this title.

"Insurance carrier" or "carrier" means an insurer providing workers' compensation coverage for an

employer. The term includes a carrier's network, provider panel, intermediary, or representative.

"Provider agreement" means any agreement, as referenced in § 65.2-605, between a provider and an insurance carrier relating to the provision of health care services.

B. Every provider agreement entered into by a provider and an employer's insurance carrier shall comply with the following:

1. Every provider agreement shall include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy, or statement as to the manner in which claims will be calculated and paid that is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules and exhibits thereto and all policies applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider agreement; and

2. No amendment to any provider agreement or to any addenda, schedule, exhibit, or policy thereto, or new addenda, schedule, exhibit, or policy, applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider, shall be effective as to the provider unless the provider has been provided with the applicable portion of the proposed amendment or of the proposed new addenda, schedule, exhibit, or policy at least 60 calendar days before the effective date and the provider has not notified the carrier within 30 calendar days of receipt of the documentation of the provider's intention to terminate the provider agreement at the earliest date thereafter permitted under the provider agreement.

C. The Commission shall have jurisdiction over disputes arising out of this section.

§ 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 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 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 ~~from the sum which benefits the third party insurance carrier or health care provider~~. Such fees shall be based on the amount paid by the employer or insurance carrier to the third party insurance carrier or health care provider for medical, surgical and hospital service rendered to the employee through the date on which the contested claim is heard before the Deputy Commissioner. 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. *The employee's attorney fees shall be the responsibility of the employer or insurance carrier that contested the compensability of the claim.*

C. Payment of any obligation pursuant to this section to any 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 an award of compensation is made pursuant to § 65.2-704 *or when an employer or the employer's insurance carrier voluntarily makes full payment for services provided to the injured employee under the terms of a valid provider agreement in advance of an award of compensation being made*. For the purpose of this subsection, a health care provider "balance bills" whenever (i) an employer or the employer's insurance carrier declines to pay all of the health care provider's charge or fee and (ii) the health care provider seeks payment of the balance from the employee.