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HOUSE BILL NO. 1820

Offered January 14, 2015

Prefiled January 13, 2015

A BILL to amend and reenact §§ 65.2-605 and 65.2-605.1 of the Code of Virginia, relating to workers' compensation; pecuniary liability for medical services.

Patrons—Farrell, Bloxom, Fariss, Howell, Jones, Knight, Lingamfelter, Massie and Minchew

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 65.2-605 and 65.2-605.1 of the Code of Virginia are amended and reenacted as follows:

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

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~~ *the amount that is generally paid to the provider* for similar treatment when *the provider is paid for* such treatment ~~is paid for~~ by ~~the injured person and the~~ *or on behalf of an individual receiving such treatment when not ordered by the Commission. The amount that is generally paid to a provider for a treatment when the provider is paid for the treatment by or on behalf of an individual receiving the treatment when not ordered by the Commission shall (i) equal 120 percent of the average amount reported to have been paid for the treatment to all providers of the treatment statewide, based on paid claims data for covered benefits collected by the Virginia All-Payer Claims Database pursuant to § 32.1-276.7:1, in the most recent year for which such paid claims data is available or (ii) if paid claims data is not available through the Virginia All-Payer Claims Database for the treatment, be established by the Commission based on evidence produced by the provider or other interested party of the average amount that the provider is paid for the treatment by or on behalf of individuals receiving the treatment when not ordered by the Commission, including payments made to the provider by health carriers as defined in § 38.2-3438, governmental agencies, employers providing health benefits under a self-insurance program, and other third-party payors.*

B. 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.~~ *C.* The pecuniary liability of the employer for treatment pursuant to subsection A 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.

~~C.~~ *D.* Multiple procedures completed on a single surgical site associated with medical, surgical, and hospital services pursuant to subsection A and rendered on or after July 1, 2014, shall be coded and billed with appropriate Current Procedural Terminology (CPT) modifiers and paid according to the National Correct Coding Initiative (NCCI) rules and the CPT as in effect at the time the health care was provided to the claimant. The CPT and NCCI, as in effect at the time such health care 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 services. Hospital in-patient health care 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 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 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~~.