VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend and reenact §§ 65.2-605 and 65.2-605.1 of the Code of Virginia, relating to an employer's liability for medical services provided outside of the Commonwealth.

[H 558]

Approved

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; 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, DRG classifications, or revenue codes.

"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, including all subsets of codes by alphabetical letter, 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.

The applicable community for providers of medical services rendered in the Commonwealth shall be determined by the zip code of the location where the services were rendered. The applicable community for providers of medical services rendered outside of the Commonwealth shall be determined by the zip code of the principal place of business of the employer if located in the Commonwealth or, if no such location exists, the zip code of the location where the Commission hearing regarding a dispute concerning the services would be conducted.

"Medical service" means any medical, surgical, or hospital service required to be provided to an

injured person pursuant to this title.

"Medical service provided for the treatment of a serious burn" includes any professional service rendered during the dates of service of the admission or transfer to a burn center.

"Medical service provided for the treatment of a traumatic injury" includes any professional service rendered during the dates of service of the admission or transfer to a Level I or Level II trauma center.

"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.

"New type of technology" means an item resulting or derived from an advance in medical technology, including an implantable medical device or an item of medical equipment, that is supplied by a third party, provided that the item has been cleared or approved by the federal Food and Drug Administration (FDA) after the transition date and prior to the date of the provision of the medical service using the item.

"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.

"Professional service" means any medical or surgical service required to be provided to an injured person pursuant to this title that is provided by a physician or any health care practitioner licensed, accredited, or certified to perform the service consistent with state law.

"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.

"Revenue codes" means a method of coding used by hospitals or health care systems to identify the department in which medical service was rendered to the patient or the type of item or equipment used in the delivery of medical services.

"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 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. *As used in this subdivision, "same community" for providers of medical services rendered outside of the Commonwealth shall be deemed to be the principal place of business of the employer if located in the Commonwealth or, if no such location exists, the location where the Commission hearing regarding the dispute is conducted*;

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 for 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, 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, in adjusting initial Virginia fee schedules pursuant to subsection D, and on all matters involving or related to the fee schedule as deemed necessary by the Commission. 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) initially equal to 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 300 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 adjust 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.

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 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.

L. The pecuniary liability of the employer for treatment 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 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 to the primary physician performing the surgery.

M. Multiple procedures completed on a single surgical site associated with a medical service rendered on or after July 1, 2014, shall be coded and billed with appropriate CPT codes and modifiers and paid according to the National Correct Coding Initiative rules and the CPT codes as in effect at the time the health care was provided to the claimant.

N. The CPT code and National Correct Coding Initiative rules, as in effect at the time 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 medical services. Hospital in-patient medical services shall be coded and billed through the International Statistical Classification of Diseases and Related Health Problems as in effect at the time the 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 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.