2015R1407

1 **Senate Bill No. 58**

2 (By Senator Yost)

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4 [Introduced January 14, 2015; referred to the Committee on Banking and Insurance; then to the

5 Committee on the Judiciary; and then to the Committee on Finance.]

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10 A BILL to amend and reenact §23-4-3 of the Code of West Virginia, 1931, as amended, relating

11 generally to workers' compensation benefits; providing quick and efficient delivery of

12 medical benefits to injured workers; providing for medical treatment that is reasonably and

13 causally related to injury; ensuring that treating doctor's opinion is not superseded by

14 guidelines; and allowing for diagnosis updates based on diagnostic testing that is consistent

15 with legislative intent set forth in said code.

16 *Be it enacted by the Legislature of West Virginia:*

17 That §23-4-3 of the Code of West Virginia, 1931, as amended, be amended and reenacted

18 to read as follows:

19 **ARTICLE 4. DISABILITY AND DEATH BENEFITS.**

20 **§23-4-3. Schedule of maximum disbursements for medical, surgical, dental and hospital**

21 **treatment; legislative approval; guidelines; preferred provider agreements;**

1 **charges in excess of scheduled amounts not to be made; required disclosure of**
2 **financial interest in sale or rental of medically related mechanical appliances or**
3 **devices; promulgation of rules to enforce requirement; consequences of failure**
4 **to disclose; contract by employer with hospital, physician, etc., prohibited;**
5 **criminal penalties for violation; payments to certain providers prohibited;**
6 **medical cost and care program; payments; interlocutory orders.**

7 (a) The Workers' Compensation Commission, and effective upon termination of the
8 commission, the Insurance Commissioner, shall establish and alter from time to time, as it
9 determines appropriate, a schedule of the maximum reasonable amounts to be paid to health care
10 providers, providers of rehabilitation services, providers of durable medical and other goods and
11 providers of other supplies and medically related items or other persons, firms or corporations for
12 the rendering of treatment or services to injured employees under this chapter. The commission and
13 effective upon termination of the commission, the Insurance Commissioner, also, on the first day of
14 each regular session and also from time to time, as it may consider appropriate, shall submit the
15 schedule, with any changes thereto, to the Legislature.

16 The commission, and effective upon termination of the commission, all private carriers and
17 self-insured employers or their agents, shall disburse and pay for personal injuries to the employees
18 who are entitled to the benefits under this chapter as follows:

19 (1)<u>(A)</u> Sums for health care services, rehabilitation services, durable medical and other goods
20 and other supplies and medically related items as may be reasonably ~~required~~ <u>and causally related</u>
21 <u>to the occupational injury.</u> The commission, and effective upon termination of the commission, all

private carriers and self-insured employers or their agents, shall determine that which is reasonably required within the meaning of this section in accordance with the guidelines developed by the health care advisory panel pursuant to section three-b of this article*: Provided,* That nothing in this section shall prevent the implementation of guidelines applicable to a particular type of treatment or service or to a particular type of injury before guidelines have been developed for other types of treatment or services or injuries: *Provided, however,* That any guidelines for utilization review which are developed in addition to the guidelines provided for in section three-b of this article may be used by the commission, and effective upon termination of the commission, all private carriers and self-insured employers or their agents, until superseded by guidelines developed by the health care advisory panel pursuant to said section: *Provided, further,* That any guidelines approved or authorized will not supersede the treating physician's opinion regarding treatment of a compensable occupational injury or disease. Each health care provider who seeks to provide services or treatment which are not within any guideline shall submit to the commission, and effective upon termination of the commission, all private carriers, self-insured employers and other payors, specific justification for the need for the additional services in the particular case and the commission shall have the justification reviewed by a health care professional before authorizing the additional services. The commission, and effective upon termination of the commission, all private carriers, self-insured employers and other payors, may enter into preferred provider and managed care agreements which provides for fees and other payments which deviate from the schedule set forth in this subsection.

(B) When the claim has been ruled compensable, any diagnostic testing that is requested causally related to the injury shall be approved. Any new diagnosis based upon the above diagnostic

testing is automatically granted, if any physician determines that the new diagnosis is causally related to the compensable injury. If the claim has been ruled compensable and diagnostic testing has been denied and delays medical treatment to the claimant, and the claimant appeals the denial, which is later reversed, then the claims administrator shall pay treble damages to the claimant for the delayed time period based upon his or her permanent partial disability rating.

A diagnosis update after one year shall require a diagnostic test, and any physician may determine that the diagnosis is causally related to the injury and that the treatment is medically reasonable and necessary.

(2) Payment for health care services, rehabilitation services, durable medical and other goods and other supplies and medically related items authorized under this subsection may be made to the injured employee or to the person, firm or corporation who or which has rendered the treatment or furnished health care services, rehabilitation services, durable medical or other goods or other supplies and items, or who has advanced payment for them, as the commission, and effective upon termination of the commission, all private carriers, self-insured employers and other payors, considers proper, but no payments or disbursements shall be made or awarded by the commission unless duly verified statements on forms prescribed by the commission, and effective upon termination of the commission, all private carriers, self-insured employers and other payors, have been filed within six months after the rendering of the treatment or the delivery of such goods, supplies or items or within ninety days of a subsequent compensability ruling if a claim is initially rejected: *Provided,* That no payment under this section shall be made unless a verified statement shows no charge for or with respect to the treatment or for or with respect to any of the items

1 specified in this subdivision has been or will be made against the injured employee or any other
2 person, firm or corporation. When an employee covered under the provisions of this chapter is
3 injured, in the course of and as a result of his or her employment and is accepted for health care
4 services, rehabilitation services, or the provision of durable medical or other goods or other supplies
5 or medically related items, the person, firm or corporation rendering the treatment may not make any
6 charge or charges for the treatment or with respect to the treatment against the injured employee or
7 any other person, firm or corporation which would result in a total charge for the treatment rendered
8 in excess of the maximum amount set forth therefor in the commission schedule set forth in this
9 subsection.

10 (3) Any pharmacist filling a prescription for medication for a workers' compensation claimant
11 shall dispense a generic brand of the prescribed medication if a generic brand exists. If a generic
12 brand does not exist, the pharmacist may dispense the name brand. In the event that a claimant
13 wishes to receive the name brand medication in lieu of the generic brand, the claimant may receive
14 the name brand medication but, in that event, the claimant is personally liable for the difference in
15 costs between the generic brand medication and the brand name medication.

16 (4) In the event that a claimant elects to receive health care services from a health care
17 provider from outside of the State of West Virginia and if that health care provider refuses to abide
18 by and accept as full payment the reimbursement made by the Workers' Compensation Commission,
19 and effective upon termination of the commission, all private carriers and self-insured employers or
20 their agents, pursuant to the schedule of maximum reasonable amounts of fees authorized by this
21 subsection, with the exceptions noted below, the claimant is personally liable for the difference

1 between the scheduled fee and the amount demanded by the out-of-state health care provider.

2 (A) In the event of an emergency where there is an urgent need for immediate medical 3 attention in order to prevent the death of a claimant or to prevent serious and permanent harm to the 4 claimant, if the claimant receives the emergency care from an out-of-state health care provider who 5 refuses to accept as full payment the scheduled amount, the claimant is not personally liable for the 6 difference between the amount scheduled and the amount demanded by the health care provider. 7 Upon the claimant's attaining a stable medical condition and being able to be transferred to either 8 a West Virginia health care provider or an out-of-state health care provider who has agreed to accept 9 the scheduled amount of fees as payment in full, if the claimant refuses to seek the specified 10 alternative health care providers, he or she is personally liable for the difference in costs between the 11 scheduled amount and the amount demanded by the health care provider for services provided after 12 attaining stability and being able to be transferred.

13 (B) In the event that there is no health care provider reasonably near to the claimant's home 14 who is qualified to provide the claimant's needed medical services who is either located in the State 15 of West Virginia or who has agreed to accept as payment in full the scheduled amounts of fees, the 16 commission, upon application by the claimant, may authorize the claimant to receive medical 17 services from another health care provider. The claimant is not personally liable for the difference 18 in costs between the scheduled amount and the amount demanded by the health care provider.

19 (b) (1) No employer shall enter into any contracts with any hospital, its physicians, officers, 20 agents or employees to render medical, dental or hospital service or to give medical or surgical 21 attention to any employee for injury compensable within the purview of this chapter and no employer

1 shall permit or require any employee to contribute, directly or indirectly, to any fund for the payment
2 of such medical, surgical, dental or hospital service within such hospital for the compensable injury.
3 Any employer violating this subsection is liable in damages to the employer's employees as provided
4 in section eight, article two of this chapter, and any employer or hospital or agent or employee
5 thereof violating the provisions of this section is guilty of a misdemeanor and, upon conviction
6 thereof, shall be punished by a fine not less than $100 nor more than $1,000 or by imprisonment not
7 exceeding one year, or both.

8 (2) The provisions of this subsection shall not prohibit an employer, the successor to the
9 commission, other private carrier or self-insured employer from participating in a managed health
10 care plan, including, but not limited to, a preferred provider organization or program or a health
11 maintenance organization or managed care organization or other medical cost containment
12 relationship with the providers of medical, hospital or other health care. An employer, successor to
13 the commission, other private carrier or self-insured employer that provides a managed health care
14 plan approved by the commission or, upon termination of the commission, the Insurance
15 Commissioner, for its employees or the employees of its insured may require an injured employee
16 to use health care providers authorized by the managed health care plan for care and treatment of his
17 or her compensable injuries. If the employer does not provide a managed health care plan or
18 program, the claimant may select his or her initial health care provider for treatment of a
19 compensable injury or disease, except as provided under subdivision (3) of this subsection. If a
20 claimant wishes to change his or her health care provider and if his or her employer has established
21 and maintains a managed health care plan, the claimant shall select a new health care provider

1 through the managed health care plan. A claimant who has used the providers under the employer’s
2 managed health care plan may select a health care provider outside the employer’s plan for treatment
3 of the compensable injury or disease if the employee receives written approval from the commission
4 to do so and the approval is given pursuant to criteria established by rule of the commission.
5 (3) If the commission enters into an agreement which has been approved by the board of
6 managers with a managed health care plan, including, but not limited to, a preferred provider
7 organization or program, a health maintenance organization or managed care organization or other
8 health care delivery organization or organizations or other medical cost containment relationship
9 with the providers of medical, hospital or other health care, then:
10 (A) If an injured employee's employer does not provide a managed health care plan approved
11 by the commission for its employees as described in subdivision (2) of this subsection, the
12 commission may require the employee to use health care providers authorized by the commission's
13 managed health care plan for care and treatment of his or her compensable injuries; and
14 (B) If a claimant seeks to change his or her initial choice of health care provider where
15 neither the employer nor the commission had an approved health care management plan at the time
16 the initial choice was made, and if the claimant's employer does not provide access to such a plan
17 as part of the employer's general health insurance benefit, then the claimant shall be provided with
18 a new health care provider from the commission's managed health care plan available to him or her.
19 (c) When an injury has been reported to the commission by the employer without protest, the
20 commission or self-insured employer may pay, within the maximum amount provided by schedule
21 established under this section, bills for health care services without requiring the injured employee

1 to file an application for benefits.

2 (d) The commission, successor to the commission, other private carrier or self-insured
3 employer, whichever is applicable, shall provide for the replacement of artificial limbs, crutches,
4 hearing aids, eyeglasses and all other mechanical appliances provided in accordance with this section
5 which later wear out, or which later need to be refitted because of the progression of the injury which
6 caused the devices to be originally furnished, or which are broken in the course of and as a result of
7 the employee's employment. The commission, successor to the commission, other private carrier or
8 self-insured employer shall pay for these devices, when needed, notwithstanding any time limits
9 provided by law.

10 (e) No payment shall be made to a health care provider who is suspended or terminated under
11 the terms of section three-c of this article except as provided in subsection (c) of said section.

12 (f) The commission, successor to the commission, other private carrier or self-insured
13 employer, whichever is applicable, may engage in and contract for medical cost containment
14 programs, pharmacy benefits management programs, medical case management programs and
15 utilization review programs. Payments for these programs shall be made from the Workers'
16 Compensation Fund or the funds of the successor to the commission, other private carrier, or
17 self-insured employer. Any order issued pursuant to the program shall be interlocutory in nature until
18 an objecting party has exhausted all review processes provided for by the commission, successor to
19 the commission, other private carrier or self-insured employer, whichever is applicable.

20 (g) Notwithstanding the provisions of this section, the commission, successor to the
21 commission, other private carrier or self-insured employer may establish fee schedules, make

1 payments and take other actions required or allowed pursuant to article twenty-nine-d, chapter
2 sixteen of this code.

NOTE: The purpose of this bill is to provide quick and efficient delivery of medical benefits to injured workers, provide for medical treatment that is reasonably and causally related to the injury, ensure that the treating doctor's opinion is not superseded by guidelines and allow for diagnosis updates based on diagnostic testing that is consistent with the legislative intent under 23-1-1(b).

Strike-throughs indicate language that would be stricken from the present law, and underscoring indicates new language that would be added.