

1 H.162

2 Introduced by Representatives Maier of Middlebury and Kitzmiller of

3 Montpelier

4 Referred to Committee on

5 Date:

6 Subject: Labor; workers' compensation; payment of medical benefits; disputes;

7 interest

8 Statement of purpose: This bill proposes to create a process for health care
9 providers to submit, dispute, and collect payment, including interest on bills
10 for medical treatment provided to an injured employee eligible for workers'
11 compensation.

12 An act relating to payment of medical benefits to health care providers

13 It is hereby enacted by the General Assembly of the State of Vermont:

14 Sec. 1. 21 V.S.A. § 601 is amended to read:

15 § 601. DEFINITIONS

16 Unless the context otherwise requires, words and phrases used in this
17 chapter shall be construed as follows:

18 * * *

19 (22) "Health care provider" ~~shall mean~~ means a person, partnership,
20 corporation, facility, or institution; licensed or certified or authorized by law to

1 provide professional health care service ~~in this state~~ to an individual during the
2 individual's medical care, treatment, or confinement.

3 * * *

4 (25) "Medical bill" means any claim, bill, or request for payment from a
5 health care provider or employee for all or any portion of health care services
6 provided to the employee for an injury for which the employee has filed a
7 claim under this chapter.

8 (26) "Denied medical payment" or "medical bill denial" means a refusal
9 to pay a medical bill based on the employer or insurance carrier asserting,
10 supported by reasonable evidence, any one or more of the following:

11 (A) The employer or insurance carrier was not provided with
12 sufficient information to determine the payer liability.

13 (B) The employer or insurance carrier was not provided with
14 reasonable access to information needed to determine the liability or basis for
15 payment of the claim.

16 (C) The employer or insurance carrier has no liability to pay a
17 medical bill based on eligibility status of the injured employee or coverage of a
18 service by the employer or insurance carrier.

19 (D) The service was not reasonable or medically necessary.

20 (E) Another payer is liable.

21 (F) Another legal or factual ground for nonpayment.

1 (27) “Medically necessary care” means health care services, including
2 diagnostic testing, preventive services, and aftercare, that is appropriate to the
3 injured employee’s diagnosis or condition in terms of type, amount, frequency,
4 level, setting, and duration and is consistent with generally accepted practice
5 parameters as recognized by health care providers in the same or similar
6 general specialty who typically treat or manage that diagnosis or condition, and
7 the treatment affects one or more of the following:

8 (A) Helps restore or maintain the patient’s health.

9 (B) Prevents deterioration or palliates the patient’s condition.

10 (C) Prevents the reasonably likely onset of a health problem or
11 detects incipient problems.

12 Sec. 2. 21 V.S.A. § 640a is added to read:

13 § 640a. MEDICAL BILLS; PAYMENT; DISPUTE

14 (a) No later than 30 days following receipt of a bill from a health care
15 provider for medical, surgical, hospital, nursing services, supplies, prescription
16 drugs, or durable medical equipment provided to an injured employee, an
17 employer or insurance carrier shall do one of the following:

18 (1) Pay or reimburse the bill.

19 (2) Provide written notification to the injured employee, the health care
20 provider, and the commissioner that the medical bill is contested or denied.

21 The notice shall include specific reasons supporting the contest or denial and a

1 description of any additional information needed by the employer or insurance
2 carrier to determine liability for the medical bill.

3 (b) Disputes regarding payment of a medical bill may be filed with the
4 commissioner by the injured employee or the health care provider. Disputes
5 regarding payment of a medical bill or interest on that bill shall be determined
6 by the commissioner or, at the option of either party, be settled by arbitration
7 in accordance with the Commercial Rules of the American Arbitration
8 Association. The decision of an arbitrator shall be provided to the
9 commissioner, and the award may be entered as a judgment in a court of
10 jurisdiction.

11 (c) If a medical bill was denied on the basis that the employer or insurance
12 carrier was not provided with sufficient information to determine liability for
13 payment pursuant to subdivision (a)(2) of this section, the employer or
14 insurance carrier has 30 days following receipt of the additional information
15 requested to pay or deny payment of the bill.

16 (d) Medical bills shall be paid within the time required in this section or
17 according to the time requirements specified in a contract between the health
18 care provider and the employer or insurance carrier.

19 (e) Interest shall accrue on an unpaid medical bill at the rate of 12 percent
20 per annum calculated as follows:

1 (1) From the first calendar day following the date the medical bill is
2 received by the employer or insurance carrier for any of the following:

3 (A) A medical bill that was not denied.

4 (B) A medical bill that was denied and written notice was not
5 provided or not provided within 30 days after receipt of the medical bill.

6 (2) For a medical bill that was denied based on insufficient information
7 and notice was provided in compliance with subdivision (a)(2) of this section,
8 from the first calendar day following 30 days after receipt of additional
9 information sufficient to determine liability for payment.

10 (3) For a medical bill that was denied and notice was provided in
11 compliance with subsection (a) of this section, from the first calendar day
12 following 30 days after the date of a final arbitration award, judgment, or
13 administrative order awarding payment of the disputed medical bill.

14 (4) For a medical bill that is paid in accordance with a contract between
15 the health care provider and the employer or insurance carrier, from the day
16 following the contract payment period or as otherwise specified in the contract.

17 (f) A health care provider shall submit a medical bill accompanied by
18 medical documentation to the employer or insurance carrier within six months
19 after the date the health care provider had actual knowledge that the services
20 provided were related to a claim under this chapter. For the purposes of this
21 section, “medical documentation” means documentation that describes an

1 injury and the treatment provided and includes all relevant treatment notes,
2 medical records, and diagnostic codes with sufficient detail to review the
3 medical necessity of the service and the appropriateness of the fee charged.
4 Failure to submit the bill within six months does not bar payment unless the
5 employer or insurance carrier is prejudiced by the delay. The commissioner
6 may extend the six-month limit if the commissioner determines that the delay
7 resulted from circumstances outside the control of the health care provider.

8 (g) A medical bill shall be submitted in a legible form with every field or
9 data element relevant to the treatment completed and treatment coding that
10 conforms to the criteria of the National Correct Coding Initiative. The medical
11 bill shall be submitted in any one of the following electronic or paper formats:

12 (1) CMS 1500 or its electronic equivalent for medical.

13 (2) UB04 or its electronic equivalent for hospital inpatient and
14 outpatient services.

15 (3) ADA J515 or its electronic equivalent for dental services.

16 (h) The commissioner may assess penalties as provided in section 688 of
17 this title against an employer or insurance carrier that fails to comply with the
18 provisions of this section and may also refer to the commissioner of banking,
19 insurance, securities, and health care administration any employer or insurance
20 carrier that neglects or refuses to pay medical bills as required by this section.

1 (i) Any interest or penalty paid by an employer or insurance carrier under
2 this chapter shall be excluded from the claims data reported pursuant to
3 8 V.S.A. § 4687.

4 Sec. 3. 21 V.S.A. § 682 is amended to read:

5 § 682. LIENS AGAINST COMPENSATION

6 (a) Claims of physicians and hospitals for services rendered under the
7 provisions of this chapter or health insurers as defined in 18 V.S.A. § 9402
8 paying a claim of a physician or hospital for services, and claims of attorneys
9 for services rendered an employee in prosecuting a claim under the provisions
10 of this chapter shall be approved by the commissioner. When so approved,
11 they may be enforced against compensation awards in such manner as the
12 commissioner may direct directs.

13 (b) A health insurer that pays a claim determined to be covered by an
14 employer or insurance carrier shall seek reimbursement from the employer or
15 insurance carrier. The health insurer and the employer or insurance carrier
16 have no claim against a physician, hospital, or an employee for those payments
17 unless permitted by the commissioner.

18 Sec. 4. 18 V.S.A. § 9418 is amended to read:

19 § 9418. PAYMENT FOR HEALTH CARE SERVICES

20 (a) As used in this section:

1 ~~These remedies are in addition to any other penalties available under Title 8~~
2 ~~and chapters 9 and 11 of Title 21.~~

3 ~~(d)~~ If a claim is contested because the health plan was not provided with
4 sufficient information to determine payer liability and for which written notice
5 has been provided as required by subdivision (b)(2) of this section, then the
6 health plan shall have 45 days after receipt of the additional information to
7 complete consideration of the claim.

8 ~~(e)~~(d) Interest shall accrue on a claim at the rate of 12 percent per annum
9 calculated as follows:

10 * * *

11 ~~(f)~~(e) The commissioner may suspend the accrual of interest under
12 subsection ~~(e)~~(d) if the commissioner determines that the health plan's failure
13 to pay a claim within the applicable time limit is the result of a major disaster,
14 act-of-God, or unanticipated major computer system failure or that the action is
15 necessary to protect the solvency of the health plan.

16 ~~(g)~~(f) All payments shall be made within the time periods provided by this
17 section unless otherwise specified in the contract between the health plan and
18 the health care provider or the health care facility. The health plan shall
19 provide notice as required by subsection (b) of this section and pay interest on
20 uncontested and contested claims as required in subsection ~~(d)~~(c) of this

1 section from the day following the contract payment period, unless otherwise
2 specified in the contract.

3 ~~(h)~~(g) Any dispute concerning payment of a claim or interest on a claim,
4 arising out of or relating to the provisions of this section shall, at the option of
5 either party, be settled by arbitration in accordance with the Commercial Rules
6 of the American Arbitration Association, and judgment upon the arbitrator's
7 award may be entered in any court having jurisdiction.

8 ~~(i)~~(h) In addition to any other remedy provided by law, if the commissioner
9 finds that a health plan has engaged in a pattern and practice of violating this
10 section, the commissioner may impose an administrative penalty against the
11 health plan of no more than \$500.00 for each violation, and may order the
12 health plan to cease and desist from further violations and order the health plan
13 to remediate the violation. In determining the amount of penalty to be
14 assessed, the commissioner shall consider the following factors:

15 * * *

16 ~~(j)~~(i) A health plan in this state shall not impose on any provider any
17 retrospective denial of a previously paid claim or any part of that previously
18 paid claim, unless:

19 * * *

20 ~~(k)~~(j) The retrospective denial of a previously paid claim shall be permitted
21 beyond 12 months from the date of payment for any of the following reasons:

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~~(k)~~(k) Notwithstanding this section, a health plan may not retroactively deny or recoup a pharmacy point-of-sale payment except in the circumstances of fraud, intentional misconduct, a member not receiving the prescription, or error in the processing of the claim.

~~(l)~~(l) Nothing in this section shall be construed to prohibit a health plan from applying payment policies that are consistent with applicable federal or state laws and regulations, or to relieve a health plan from complying with payment standards established by federal or state laws and regulations, including rules adopted by the commissioner pursuant to section 9408 of this title relating to claims administration and adjudication standards, and rules adopted by the commissioner pursuant to section 9414 of this title and section 4088f of Title 8, relating to pay for performance or other payment methodology standards.

~~(m)~~(m) The provisions of this section shall not apply to stand-alone dental plans ~~or to a workers' compensation policy of a casualty insurer~~ licensed to do business in Vermont.

Sec. 5. 18 V.S.A. § 9418a(a)(3) is amended to read:

(3) "Health plan" means a health insurer, disability insurer, health maintenance organization, or medical or hospital service corporation licensed to do business in Vermont, but does not include a stand-alone dental plan ~~or a~~

1 ~~workers' compensation policy of a casualty insurer licensed to do business in~~
2 ~~Vermont.~~ "Health plan" also includes a health plan that requires its medical
3 groups, independent practice associations, or other independent contractors to
4 pay claims for the provision of health care services.

5 Sec. 6. 18 V.S.A. § 9418b(a)(2) is amended to read:

6 (2) "Health plan" means a health insurer, disability insurer, health
7 maintenance organization, or medical or hospital service corporation licensed
8 to do business in Vermont, but does not include a stand-alone dental plan ~~or a~~
9 ~~workers' compensation policy of a casualty insurer licensed to do business in~~
10 ~~Vermont.~~ "Health plan" also includes a health plan that requires its medical
11 groups, independent practice associations, or other independent contractors to
12 pay claims for the provision of health care services.