

*** * * Workers' Compensation Medical Claim Payment Standards * * ***

Sec. 26. 21 V.S.A. § 601 is amended to read:

21 V.S.A. § 601. DEFINITIONS

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

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(22) "Health care provider" shall mean means a person, partnership, corporation, facility, or institution, licensed or certified or authorized by law to provide professional health care service in this state to an individual during the individual's medical care, treatment, or confinement.

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

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

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

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

(C) The employer or insurance carrier has no liability to pay a medical bill under the provisions of this chapter.

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

(E) Another payer is liable.

(F) Another legal or factual ground for nonpayment.

(27) "Medically necessary care" means health care services for which an employer is otherwise liable under the provisions of this chapter, including diagnostic testing, preventive services, and aftercare, that are appropriate, in terms of type, amount, frequency, level, setting, and duration, to the injured employee's diagnosis or condition. Medically necessary care must be informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters as recognized by health care professionals in the same specialties as typically provide the procedure or treatment, or diagnose or manage the medical condition; must be informed by the unique needs of each individual patient and each presenting situation; and must:

(A) help restore or maintain the injured employee's health; or

(B) prevent deterioration of or palliate the injured employee's condition; or

(C) prevent the reasonably likely onset of a health problem or detect an incipient problem.

Sec. 27. 21 V.S.A. § 640a is added to read:

21 V.S.A. § 640a. MEDICAL BILLS; PAYMENT; DISPUTE

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

(1) Pay or reimburse the bill.

(2) Provide written notification to the injured employee, the health care provider, and the commissioner that the medical bill is contested or denied. The notice shall include specific reasons supporting the contest or denial, a description of any additional information needed by the employer or insurance carrier to determine liability for the medical bill, and a request that such information be submitted to the employer or insurance carrier within 30 days following receipt of the notice.

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

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

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

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

(1) From the first calendar day following 30 days after the date the medical bill is received by the employer or insurance carrier for any of the following:

(A) A medical bill that was not denied.

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

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

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

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

(f) A health care provider shall submit a medical bill accompanied by medical documentation to the employer or insurance carrier within six months after the date the health care provider had actual knowledge that the services provided were related to a claim under this chapter. For the purposes of this section, "medical documentation" means documentation that describes an injury and the treatment provided and includes all relevant treatment notes, medical records, and diagnostic codes with sufficient detail to review the medical necessity of the service and the appropriateness of the fee charged. Failure to submit the bill within six months does not bar payment unless the employer or insurance carrier is prejudiced by the delay. The commissioner may extend the six-month limit if the commissioner determines that the delay resulted from circumstances outside the control of the health care provider.

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

- (1) CMS 1500 or its electronic equivalent for medical.
- (2) UB04 or its electronic equivalent for hospital inpatient and outpatient services.
- (3) ADA J515 or its electronic equivalent for dental services.

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

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

(j) An employer or insurance carrier shall not impose on any health care provider any retrospective denial of a previously paid medical bill or any part of that previously paid medical bill, unless:

- (1) The employer or insurance carrier has provided at least 30 days'

notice of any retrospective denial or overpayment recovery or both in writing to the health care provider. The notice must include:

- (A) the injured employee's name;
- (B) the service date;
- (C) the payment amount;
- (D) the proposed adjustment; and
- (E) a reasonably specific explanation of the proposed adjustment.

(2) The time that has elapsed does not exceed 12 months from the later of the date of payment of the previously paid medical bill or the date of a final determination of compensability.

(k) The retrospective denial of a previously paid medical bill shall be permitted beyond 12 months from the later of the date of payment or the date of a final determination of compensability for any of the following reasons:

(1) The employer or insurance carrier has a reasonable belief that fraud or other intentional misconduct has occurred;

(2) The medical bill payment was incorrect because the health care provider was already paid for the health services identified in the medical bill;

(3) The health care services identified in the medical bill were not delivered by the health care provider;

(4) The medical bill payment is the subject of adjustment with another workers' compensation or health insurer; or

(5) The medical bill is the subject of legal action.

(l) (1) For purposes of subsections (j) and (k) of this section, for routine recoveries as described in subdivisions (A) through (J) of this subdivision (1), retrospective denial or overpayment recovery of any or all of a previously paid medical bill shall not require 30 days' notice before recovery may be made. A recovery shall be considered routine only if one of the following situations applies:

(A) Duplicate payment to a health care provider for the same professional service;

(B) Payment with respect to an individual for whom the employer or insurance carrier is not liable as of the date the service was provided;

(C) Payment for a noncovered service, not to include services denied as not medically necessary, experimental, or investigational in nature, or services denied through a utilization review mechanism;

(D) Erroneous payment for services due to employer or insurance carrier administrative error;

(E) Erroneous payment for services where the medical bill was processed in a manner inconsistent with the data submitted by the health care provider;

(F) Payment where the health care provider provides the employer or insurance carrier with new or additional information demonstrating an overpayment;

(G) Payment to a health care provider at an incorrect rate or using an incorrect fee schedule;

(H) Payment of medical bills for the same injured employee that are received by the employer or insurance carrier out of the chronological order in which the services were performed;

(I) Payment where the health care provider has received payment for the same services from another payer whose obligation is primary; or

(J) Payments made in coordination with a payment by a government payer that require adjustment based on an adjustment in the government-paid portion of the medical bill.

(2) Notwithstanding the provisions of subdivision (1) of this subsection, recoveries which, in the reasonable business judgment of the employer or insurance carrier, would be likely to affect a significant volume of claims or accumulate to a significant dollar amount shall not be deemed routine, regardless of whether one or more of the situations in subdivisions (1)(A) through (J) of this subsection apply.

(3) Nothing in this subsection shall be construed to affect the time frames established in subdivision (j)(2) or subsection (k) of this section.