SECOND REGULAR SESSION

HOUSE BILL NO. 1250

92ND GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES CUNNINGHAM (86) (Sponsor) AND PHILLIPS (Co-sponsor).

Read 1st time January 26, 2004, and copies ordered printed.

STEPHEN S. DAVIS, Chief Clerk

3417L.01I

AN ACT

To repeal sections 287.135 and 287.140, RSMo, and to enact in lieu thereof two new sections relating to workers' compensation insurance, with penalty provisions.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Sections 287.135 and 287.140, RSMo, are repeated and two new sections enacted in lieu thereof, to be known as sections 287.135 and 287.140, to read as follows:

287.135. 1. The department of insurance shall establish a program whereby managed care organizations in this state shall be certified by the department for the provision of managed care services to employers who voluntarily choose to use such organizations. The department shall report to the division of workers' compensation all managed care organizations certified pursuant to the provisions of this section. The division shall maintain a registry of certified managed care organizations that can be readily accessed by employers for the provision of managed care services. For the purposes of this section, the term "managed care organizations" shall mean organizations such as preferred provider organizations, health maintenance organizations and other direct employer/provider arrangements which have been certified by the department designed to provide incentives to medical care providers to manage the cost and use of care associated with claims covered by workers' compensation insurance.

EXPLANATION — Matter enclosed in bold faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law. Matter in boldface type in the above law is proposed language.

2. The director of the department of insurance shall promulgate rules which set out the approval criteria for certification of a managed care organization. Approval criteria shall take into consideration the adequacy of services that the organization will be able to offer the employer, the geographic area to be served, staff size and makeup of the organization in relation to both services offered and geographic location, access to health care providers, the adequacy of internal management and oversight, the adequacy of procedures for peer review, utilization review, and internal dispute resolution, including a method to resolve complaints by injured employees, medical providers, and insurers over the cost, necessity and appropriateness of medical services, the availability of case management services, and any other criteria as determined by the director. Thirty days prior to the annual anniversary of any current certification granted by the director, any managed care organization seeking continued certification shall file an application for recertification with the director, on a form approved by the director, accompanied by a filing fee established by the director by rule and any other materials specified by the director.

3. **[**The director of the department of insurance shall promulgate rules which set out the criteria under which**]** The fees charged by a managed care organization shall be reimbursed by an employer's workers' compensation insurer **[**and which**]. The director of the department of insurance shall** establish criteria providing for the coordination and integration between the managed care organization and the insurer of their respective internal operational systems relating to such matters as claim reporting and handling, medical case management procedures and billing. Such criteria shall require any such reimbursable fees to be reasonable in relation both to the managed care services provided and to the savings which result from those services. Such criteria shall discourage the use of fee arrangements which result in unjustified costs being billed for either medical services or managed care services. Insurers and managed care organizations shall be permitted to voluntarily negotiate and utilize alternative fee arrangements. Notwithstanding any provision of this subsection to the contrary, if an insurer and a managed care organization enter into a voluntary agreement that accomplishes the same purposes as this subsection, that insurer and that managed care organization with respect to that agreement shall not be required to meet the requirements of this subsection or regulations promulgated by the

department pursuant to this subsection. **The fact that an insurer enters into a voluntary agreement with one or more managed care organizations shall not exempt such insurer from the requirements of this subsection or regulations promulgated thereto regarding other managed care organizations for which the insurer has no such voluntary agreements but with which employers insured by such insurer have contracted. The insurer shall comply with the requirements of this subsection and all regulations promulgated thereto, including requirements concerning the reimbursement of such organizations, in regards to such other managed care organizations.**

4. Any managed care organization, including any managed care organization that has been established or selected by or has contracted with a workers' compensation insurance carrier to provide managed care services to insured employers, that has previously been certified prior to August 28, 1993, by the director of the department of insurance shall be deemed to have met the criteria set forth in this section.

5. The necessity and appropriateness of medical care services recommended or provided by providers shall be subject to review by the division of workers' compensation, upon application, following a decision by the managed care organization's utilization review and dispute resolution review and appeal procedure. The decision of the managed care organization relating to payment for such medical care services shall be subject to modification by the division of workers' compensation, after mediation conference or hearing, only upon showing that it was unreasonable, arbitrary or capricious.

287.140. 1. In addition to all other compensation, the employee shall receive and the employer shall provide such medical, surgical, chiropractic, and hospital treatment, including nursing, custodial, ambulance and medicines, as may reasonably be required after the injury or disability, to cure and relieve from the effects of the injury. If the employee desires, **[**he**]** **the employee** shall have the right to select his **or her** own physician, surgeon, or other such requirement at **[**his**]** **the employee's** own expense. Where the requirements are furnished by a public hospital or other institution, payment therefor shall be made to the proper authorities. Regardless of whether the health care provider is selected by the employer or is selected by the employee at the employee's expense, the health care provider shall have the affirmative duty to

communicate fully with the employee regarding the nature of the employee's injury and recommended treatment exclusive of any evaluation for a permanent disability rating. Failure to perform such duty to communicate shall constitute a disciplinary violation by the provider subject to the provisions of chapter 620, RSMo. When an employee is required to submit to medical examinations or necessary medical treatment at a place outside of the local or metropolitan area from the place of injury or the place of **[**his**]** **the employee's** residence, the employer or its insurer shall advance or reimburse the employee for all necessary and reasonable expenses; except that an injured employee who resides outside the state of Missouri and who is employed by an employer located in Missouri shall have the option of selecting the location of services provided in this section either at a location within one hundred miles of the injured employee's residence, place of injury or place of hire by the employer. The choice of provider within the location selected shall continue to be made by the employer. In case of a medical examination if a dispute arises as to what expenses shall be paid by the employer, the matter shall be presented to the legal advisor, the administrative law judge or the commission, who shall set the sum to be paid and same shall be paid by the employer prior to the medical examination. In no event, however, shall the employer or its insurer be required to pay transportation costs for a greater distance than two hundred fifty miles each way from place of treatment. In addition to all other payments authorized or mandated under this subsection, when an employee who has returned to full-time employment is required to submit to a medical examination for the purpose of evaluating permanent disability, or to undergo physical rehabilitation, the employer or its insurer shall pay a proportionate weekly compensation benefit based on the provisions of section 287.180 for such wages that are lost due to time spent undergoing such medical examinations or physical rehabilitation, except that where the employee is undergoing physical rehabilitation, such proportionate weekly compensation benefit payment shall be limited to a time period of no more than twenty weeks. For purposes of this subsection only, "physical rehabilitation" shall mean the restoration of the seriously injured person as soon as possible and as nearly as possible to a condition of self-support and maintenance as an able-bodied worker. Determination as to what care and restoration constitutes physical rehabilitation shall be the sole province of the treating physician. Should the employer or its insurer contest the determination of the treating

physician, then the director shall review the case at question and issue **[**his**]** **a** determination. Such determination by the director shall be appealable like any other finding of the director or the division. Serious injury includes, but is not limited to, quadriplegia, paraplegia, amputations of hand, arm, foot or leg, atrophy due to nerve injury or nonuse, and back injuries not amenable alone to recognized medical and surgical procedures.

2. If it be shown to the division or the commission that the requirements are being furnished in such manner that there is reasonable ground for believing that the life, health, or recovery of the employee is endangered thereby, the division or the commission may order a change in the physician, surgeon, hospital or other requirement.

3. All fees and charges under this chapter shall be fair and reasonable, shall be subject to regulation by the division or the commission, or the board of rehabilitation in rehabilitation cases. A health care provider shall not charge a fee for treatment and care which is governed by the provisions of this chapter greater than the usual and customary fee the provider receives for the same treatment or service when the payor for such treatment or service is a private individual or a private health insurance carrier. The division or the commission, or the board of rehabilitation in rehabilitation cases, shall also have jurisdiction to hear and determine all disputes as to such charges. A health care provider is bound by the determination upon the reasonableness of health care bills.

4. The division shall, by regulation, establish methods to resolve disputes concerning the reasonableness of medical charges, services, or aids. This regulation shall govern resolution of disputes between employers and medical providers over fees charged, whether or not paid, and shall be in lieu of any other administrative procedure under this chapter. The employee shall not be a party to a dispute over medical charges, nor shall the employee's recovery in any way be jeopardized because of such dispute.

5. No compensation shall be payable for the death or disability of an employee, if and insofar as the death or disability may be caused, continued or aggravated by any unreasonable refusal to submit to any medical or surgical treatment or operation, the risk of which is, in the opinion of the division or the commission, inconsiderable in view of the seriousness of the injury. If the employee dies as a result of an operation made necessary by the injury, the death

shall be deemed to be caused by the injury.

6. The testimony of any physician or chiropractic physician who treated the employee shall be admissible in evidence in any proceedings for compensation under this chapter, subject to all of the provisions of section 287.210.

7. Every hospital or other person furnishing the employee with medical aid shall permit its record to be copied by and shall furnish full information to the division or the commission, the employer, the employee or **[**his**]** **the employee's** dependents and any other party to any proceedings for compensation under this chapter, and certified copies of the records shall be admissible in evidence in any such proceedings.

8. The employer may be required by the division or the commission to furnish an injured employee with artificial legs, arms, hands, surgical orthopedic joints, or eyes, or braces, as needed, for life whenever the division or the commission shall find that the injured employee may be partially or wholly relieved of the effects of a permanent injury by the use thereof. The director of the division shall establish a procedure whereby a claim for compensation may be reactivated after settlement of such claim is completed. The claim shall be reactivated only after the claimant can show good cause for the reactivation of this claim and the claim shall be made only for the payment of medical procedures involving life-threatening surgical procedures or if the claimant requires the use of a new, or the modification, alteration or exchange of an existing, prosthetic device. For the purpose of this subsection, "life threatening" shall mean a situation or condition which, if not treated immediately, will likely result in the death of the injured worker.

9. Nothing in this chapter shall prevent an employee being provided treatment for **[**his**]** injuries by prayer or spiritual means if the employer does not object to the treatment.

10. The employer shall have the right to select the licensed treating physician, surgeon, chiropractic physician, **network of providers,** or other health care provider**, including licensed registered nurses functioning as medical case managers**; provided, however, that such physicians, surgeons**, registered nurses,** or other health care providers shall offer only those services authorized within the scope of their licenses. For the purpose of this subsection, subsection 2 of section 287.030 shall not apply.

11. Any physician or other health care provider who orders, directs or refers a patient for treatment, testing, therapy or rehabilitation at any institution or facility shall, at or prior to the time of the referral, disclose in writing if such health care provider, any of **[**his**] the provider's** partners or **[**his**] the provider's** employer has a financial interest in the institution or facility to which the patient is being referred, to the following:

(1) The patient;

(2) The employer of the patient with workers' compensation liability for the injury or disease being treated;

(3) The workers' compensation insurer of such employer; and

(4) The workers' compensation adjusting company for such insurer.

12. Violation of subsection 11 of this section is a class A misdemeanor.

13. (1) No hospital, physician or other health care provider, other than a hospital, physician or health care provider selected by the employee at **[**his**] the employee's** own expense pursuant to subsection 1 of this section, shall bill or attempt to collect any fee or any portion of a fee for services rendered to an employee due to a work-related injury or report to any credit reporting agency any failure of the employee to make such payment, when an injury covered by this chapter has occurred and such hospital, physician or health care provider has received actual notice given in writing by the employee, the employer or the employer's insurer. Actual notice shall be deemed received by the hospital, physician or health care provider five days after mailing by certified mail by the employer or insurer to the hospital, physician or health care provider.

(2) The notice shall include:

(a) The name of the employer;

(b) The name of the insurer, if known;

(c) The name of the employee receiving the services;

(d) The general nature of the injury, if known; and

(e) Where a claim has been filed, the claim number, if known.

(3) When an injury is found to be noncompensable under this chapter, the hospital, physician or other health care provider shall be entitled to pursue the employee for any unpaid

portion of the fee or other charges for authorized services provided to the employee. Any applicable statute of limitations for an action for such fees or other charges shall be tolled from the time notice is given to the division by a hospital, physician or other health care provider pursuant to subdivision (6) of this subsection, until a determination of noncompensability in regard to the injury which is the basis of such services is made, or in the event there is an appeal to the labor and industrial relations commission, until a decision is rendered by that commission.

(4) If a hospital, physician or other health care provider or a debt collector on behalf of such hospital, physician or other health care provider pursues any action to collect from an employee after such notice is properly given, the employee shall have a cause of action against the hospital, physician or other health care provider for actual damages sustained plus up to one thousand dollars in additional damages, costs and reasonable attorney's fees.

(5) If an employer or insurer fails to make payment for authorized services provided to the employee by a hospital, physician or other health care provider pursuant to this chapter, the hospital, physician or other health care provider may proceed pursuant to subsection 4 of this section with a dispute against the employer or insurer for any fees or other charges for services provided.

(6) A hospital, physician or other health care provider whose services have been authorized in advance by the employer or insurer may give notice to the division of any claim for fees or other charges for services provided for a work-related injury that is covered by this chapter, with copies of the notice to the employee, employer and the employer's insurer. Where such notice has been filed, the administrative law judge may order direct payment from the proceeds of any settlement or award to the hospital, physician or other health care provider for such fees as are determined by the division. The notice shall be on a form prescribed by the division.