H-2043.1

SECOND SUBSTITUTE HOUSE BILL 1523

State of Washington 62nd Legislature 2011 Regular Session

By House Ways & Means (originally sponsored by Representatives Carlyle and Hunter; by request of Health Care Authority and Department of Social and Health Services)

READ FIRST TIME 02/25/11.

AN ACT Relating to electronic transactions by state purchased social and health care programs; amending RCW 51.04.030, 7.68.030, and 51.52.050; adding a new section to chapter 41.05 RCW; adding a new section to chapter 43.20A RCW; and creating a new section.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** A new section is added to chapter 41.05 RCW to read as follows:

(1) Except as otherwise provided in this section, each contractor, provider, or vendor must submit and receive transactions with the authority electronically in the manner and format prescribed in this section and by the authority. For purpose of this section, "transactions" include, but are not limited to, authorization, billing, or receipt of payment for state purchased health care services, as defined in RCW 41.05.011, that are administered by the authority.

(2) Contracts between the authority and health carriers, as defined in RCW 48.43.005, or third-party administrators for the provision or administration of health care services shall include a provision requiring the carrier or third-party administrator to condition payment for health care services upon their network health care providers

billing and receiving payment for services electronically. This requirement must be implemented no later than July 2012, or the effective date of contracts executed under any upcoming contract procurement.

(3) The authority shall waive the requirements of this section upon a written request that demonstrates one or more of the following:

(a) The health care provider or vendor delivers timely access to care or services for which there is a critical need in the geographic area served by the provider or vendor;

(b) The health care provider or vendor has service interruptions or inadequate internet service in their community and has low claim volume; or

(c) The health care provider or vendor is a newly contracted provider or vendor and needs sufficient time to be able to comply with the requirements of this section.

(4) Transactions that are not submitted electronically in the manner and format prescribed by the authority may be returned without processing.

(5) The authority must adopt any rules it deems necessary to implement the provisions of this section, including an administrative processing fee for any charge that is not submitted electronically in the manner and format specified by the authority.

(6) The authority must work in good faith with contractors, providers, and vendors that have not obtained a waiver to allow each sufficient time to transition to the electronic submissions considering their circumstances including size, transaction volume, and available financial and labor resources.

NEW SECTION. **Sec. 2.** A new section is added to chapter 43.20A RCW to read as follows:

(1) Except as otherwise provided in this section, each contractor, provider, or vendor must submit and receive transactions with the department electronically in the manner and format prescribed in this section and by the department. For purpose of this section, "transactions" include, but are not limited to, authorization, billing, or receipt of payment for state purchased health care services, as defined in RCW 41.05.011.

(2) The department shall implement the requirements under this section in phases as follows:

(a) For transactions processed through the state's medicaid management information system, the department shall require: (i) Institutional and professional claims to be submitted and paid electronically by January 2012; (ii) dental claims to be submitted and paid electronically by July 2012; and (iii) service authorizations to be submitted electronically by January 2013; and

(b) Contracts between the authority and health carriers, as defined in RCW 48.43.005, or third-party administrators for the provision or administration of health care services shall include a provision requiring the carrier or third-party administrator to condition payment for health care services upon their network health care providers billing and receiving payment for services electronically. This requirement must be implemented no later than July 2012, or the effective date of contracts executed under any upcoming contract procurement.

(3) The department shall waive the requirements of this section upon a written request that demonstrates one or more of the following circumstances:

(a) The health care provider or vendor delivers timely access to care or services for which there is a critical need in the geographic area served by the provider or vendor;

(b) The health care provider or vendor has service interruptions or inadequate internet service in their community and who has low claim volume; or

(c) The health care provider or vendor is a newly contracted provider or vendor and needs sufficient time to be able to comply with the requirements of this section.

(4) Transactions that are not submitted electronically in the manner and format prescribed by the department may be returned without processing.

(5) The department must adopt any rules it deems necessary to implement the provisions of this section, including an administrative processing fee for any charge that is not submitted electronically in the manner and format specified by the department.

(6) The department shall work in good faith with contractors, providers, and vendors that have not obtained waivers to allow each

sufficient time to transition to the electronic submissions considering their circumstances including size, transaction volume, and available financial and labor resources.

Sec. 3. RCW 51.04.030 and 2004 c 65 s 1 are each amended to read as follows:

(1) The director shall supervise the providing of prompt and efficient care and treatment, including care provided by physician assistants governed by the provisions of chapters 18.57A and 18.71A RCW, acting under a supervising physician, including chiropractic care, and including care provided by licensed advanced registered nurse practitioners, to workers injured during the course of their employment at the least cost consistent with promptness and efficiency, without discrimination or favoritism, and with as great uniformity as the various and diverse surrounding circumstances and locations of industries will permit and to that end shall, from time to time, establish and adopt and supervise the administration of printed forms, rules, regulations, and practices for the furnishing of such care and treatment: PROVIDED, That the medical coverage decisions of the department do not constitute a "rule" as used in RCW 34.05.010(16), nor are such decisions subject to the rule-making provisions of chapter 34.05 RCW except that criteria for establishing medical coverage decisions shall be adopted by rule after consultation with the workers' compensation advisory committee established in RCW 51.04.110: PROVIDED FURTHER, That the department may recommend to an injured worker particular health care services and providers where specialized treatment is indicated or where cost effective payment levels or rates are obtained by the department: AND PROVIDED FURTHER, That the department may enter into contracts for goods and services including, but not limited to, durable medical equipment so long as statewide access to quality service is maintained for injured workers.

(2) The director shall, in consultation with interested persons, establish and, in his or her discretion, periodically change as may be necessary, and make available a fee schedule of the maximum charges to be made by any physician, surgeon, chiropractor, hospital, druggist, licensed advanced registered nurse practitioner, physicians' assistants as defined in chapters 18.57A and 18.71A RCW, acting under a supervising physician or other agency or person rendering services to

injured workers. The department shall coordinate with other state purchasers of health care services to establish as much consistency and uniformity in billing and coding practices as possible, taking into account the unique requirements and differences between programs. No service covered under this title, including services provided to injured workers, whether aliens or other injured workers, who are not residing in the United States at the time of receiving the services, shall be charged or paid at a rate or rates exceeding those specified in such fee schedule, and no contract providing for greater fees shall be valid as to the excess. The establishment of such a schedule, exclusive of conversion factors, does not constitute "agency action" as used in RCW 34.05.010(3), nor does such a fee schedule constitute a "rule" as used in RCW 34.05.010(16).

(3) The director or self-insurer, as the case may be, shall make a record of the commencement of every disability and the termination thereof and, when bills are rendered for the care and treatment of injured workers, shall approve and pay those which conform to the adopted rules, ((~~regulations,~~)) established fee schedules, and practices of the director and may reject any bill or item thereof incurred in violation of the principles laid down in this section or the rules((~~, regulations,~~)) or the established fee schedules and rules ((~~and regulations~~)) adopted under it.

(4)(a) Except as otherwise provided in this section, each medical or vocational provider must submit and receive transactions with the department electronically in the manner and format prescribed by the department. For the purposes of this section, "transactions" include, but are not limited to, billing, receipt of payments and remittance advice documents, requests for authorization of medical services, and applications to be a provider who treats injured workers.

(b) The department shall exempt a provider from the requirements of this section upon a request that demonstrates one or more of the following circumstances:

(i) For initial transactions for new providers during their first three months of participation;

(ii) There is a need to provide access to care when other appropriate options are unavailable or would cause substantial delays;

(iii) The provider engages in minimal transactions with the department; and

(iv) The provider's community has inadequate internet service or service interruptions.

(c) The department shall adopt rules necessary to implement this section, including the criteria for any exemptions. The rules must implement requirements for authorization, billing, payment, and remittance advice documents in the following phases:

(i) By July 1, 2012, medical and vocational providers must be required to bill the department electronically;

(ii) By January 1, 2014, medical and vocational providers must be required to receive payments and remittance advice documents electronically; and

(iii) By January 1, 2015, medical providers must be required to submit authorization requests electronically for services requiring preauthorization.

(iv) The department must work in good faith with contractors, providers, and vendors that have not obtained waivers to allow each sufficient time to transition to the electronic submissions considering their circumstances including size, transaction volume, and available financial and labor resources.

Sec. 4. RCW 7.68.030 and 2009 c 479 s 7 are each amended to read as follows:

(1) It shall be the duty of the director to establish and administer a program of benefits to innocent victims of criminal acts within the terms and limitations of this chapter. In so doing, the director shall, in accordance with chapter 34.05 RCW, adopt rules and regulations necessary to the administration of this chapter, and the provisions contained in chapter 51.04 RCW, including but not limited to RCW 51.04.020, 51.04.030, 51.04.040, 51.04.050 and 51.04.100 as now or hereafter amended, shall apply where appropriate in keeping with the intent of this chapter. The director may apply for and, subject to appropriation, expend federal funds under Public Law 98-473 and any other federal program providing financial assistance to state crime victim compensation programs. The federal funds shall be deposited in the state general fund and may be expended only for purposes authorized by applicable federal law.

(2)(a) Except as otherwise provided by this section, each medical provider must submit and receive transactions with the department

electronically in the manner and format prescribed by the department. For the purposes of this section, "transactions" include, but are not limited to, billing, receipt of payments and remittance advice documents, and applications to be a provider who treats crime victims.

(b) The department shall exempt a provider from the requirements of this section upon a written request that demonstrates one or more of the following circumstances:

(i) For initial transactions for new providers during their first three months of participation;

(ii) There is a need to provide access to care when other appropriate options are unavailable or would cause substantial delays;

(iii) The provider engages in minimal transactions with the department; and

(iv) The provider's community has inadequate internet service or service interruptions.

(c) The department shall adopt rules necessary to implement this section, including the criteria for any exemptions. The rules must implement requirements for authorization, billing, payment, and remittance advice documents in the following phases:

(i) By July 1, 2012, medical providers must be required to bill the department electronically; and

(ii) By January 1, 2014, medical providers must be required to receive payments and remittance advice documents electronically.

(iii) The department shall work in good faith with contractors, providers, and vendors that have not obtained waivers to allow each sufficient time to transition to the electronic submissions considering their circumstances including size, transaction volume, and available financial and labor resources.

Sec. 5. RCW 51.52.050 and 2008 c 280 s 1 are each amended to read as follows:

(1) Whenever the department has made any order, decision, or award, it shall promptly serve the worker, beneficiary, employer, or other person affected thereby, with a copy thereof by mail, ((~~which shall be addressed to such person at his or her last known address as shown by the records of the department~~)) or if the worker, beneficiary, employer, or other person affected thereby chooses, the department may send correspondence and other legal notices by secure electronic means.

Correspondence and notices must be addressed to such a person at his or her last known postal or electronic address as shown by the records of the department. Correspondence and notices sent electronically are considered received on the date sent by the department. The copy, in case the same is a final order, decision, or award, shall bear on the same side of the same page on which is found the amount of the award, a statement, set in black faced type of at least ten point body or size, that such final order, decision, or award shall become final within sixty days from the date the order is communicated to the parties unless a written request for reconsideration is filed with the department of labor and industries, Olympia, or an appeal is filed with the board of industrial insurance appeals, Olympia. However, a department order or decision making demand, whether with or without penalty, for repayment of sums paid to a provider of medical, dental, vocational, or other health services rendered to an industrially injured worker, shall state that such order or decision shall become final within twenty days from the date the order or decision is communicated to the parties unless a written request for reconsideration is filed with the department of labor and industries, Olympia, or an appeal is filed with the board of industrial insurance appeals, Olympia.

(2)(a) Whenever the department has taken any action or made any decision relating to any phase of the administration of this title the worker, beneficiary, employer, or other person aggrieved thereby may request reconsideration of the department, or may appeal to the board. In an appeal before the board, the appellant shall have the burden of proceeding with the evidence to establish a prima facie case for the relief sought in such appeal.

(b) An order by the department awarding benefits shall become effective and benefits due on the date issued. Subject to (b)(i) and (ii) of this subsection, if the department order is appealed the order shall not be stayed pending a final decision on the merits unless ordered by the board. Upon issuance of the order granting the appeal, the board will provide the worker with notice concerning the potential of an overpayment of benefits paid pending the outcome of the appeal and the requirements for interest on unpaid benefits pursuant to RCW 51.52.135. A worker may request that benefits cease pending appeal at any time following the employer's motion for stay or the board's order

granting appeal. The request must be submitted in writing to the employer, the board, and the department. Any employer may move for a stay of the order on appeal, in whole or in part. The motion must be filed within fifteen days of the order granting appeal. The board shall conduct an expedited review of the claim file provided by the department as it existed on the date of the department order. The board shall issue a final decision within twenty-five days of the filing of the motion for stay or the order granting appeal, whichever is later. The board's final decision may be appealed to superior court in accordance with RCW 51.52.110. The board shall grant a motion to stay if the moving party demonstrates that it is more likely than not to prevail on the facts as they existed at the time of the order on appeal. The board shall not consider the likelihood of recoupment of benefits as a basis to grant or deny a motion to stay. If a self-insured employer prevails on the merits, any benefits paid may be recouped pursuant to RCW 51.32.240.

(i) If upon reconsideration requested by a worker or medical provider, the department has ordered an increase in a permanent partial disability award from the amount reflected in an earlier order, the award reflected in the earlier order shall not be stayed pending a final decision on the merits. However, the increase is stayed without further action by the board pending a final decision on the merits.

(ii) If any party appeals an order establishing a worker's wages or the compensation rate at which a worker will be paid temporary or permanent total disability or loss of earning power benefits, the worker shall receive payment pending a final decision on the merits based on the following:

(A) When the employer is self-insured, the wage calculation or compensation rate the employer most recently submitted to the department; or

(B) When the employer is insured through the state fund, the highest wage amount or compensation rate uncontested by the parties.

Payment of benefits or consideration of wages at a rate that is higher than that specified in (b)(ii)(A) or (B) of this subsection is stayed without further action by the board pending a final decision on the merits.

(c) In an appeal from an order of the department that alleges willful misrepresentation, the department or self-insured employer

shall initially introduce all evidence in its case in chief. Any such person aggrieved by the decision and order of the board may thereafter appeal to the superior court, as prescribed in this chapter.

NEW SECTION. **Sec. 6.** Any action taken by an agency to implement the provisions of this act must be accomplished within existing resources.

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