STATE OF OKLAHOMA

1st Session of the 58th Legislature (2021)

SENATE BILL 724 By: Dahm

AS INTRODUCED

An Act relating to the Physician Advisory Committee; amending Section 50, Chapter 208, O.S.L. 2013, as last amended by Section 1, Chapter 34, O.S.L. 2020 (85A O.S. Supp. 2020, Section 50), which relates to medical examination and treatment; removing authority to establish parameters for certain maintenance or treatment; repealing Section 17, Chapter 208, O.S.L. 2013 (85A O.S. Supp. 2020, Section 17), which relates to appointment and duties; repealing Section 60, Chapter 208, O.S.L. 2013, as amended by Section 22, Chapter 476, O.S.L. 2019 (85A O.S. Supp. 2020, Section 60), which relates to adoption of alternative method to evaluate permanent disability; and providing an effective date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. AMENDATORY Section 50, Chapter 208, O.S.L. 2013, as last amended by Section 1, Chapter 34, O.S.L. 2020 (85A O.S. Supp. 2020, Section 50), is amended to read as follows:

Section 50. A. The employer shall promptly provide an injured employee with medical, surgical, hospital, optometric, podiatric, chiropractic and nursing services, along with any medicine, crutches, ambulatory devices, artificial limbs, eyeglasses, contact lenses, hearing aids~~,~~ and other apparatus as may be reasonably

necessary in connection with the injury received by the employee. The employer shall have the right to choose the treating physician or chiropractor.

B. If the employer fails or neglects to provide medical treatment within five (5) days after actual knowledge is received of an injury, the injured employee may select a physician or chiropractor to provide medical treatment at the expense of the employer; provided, however, that the injured employee, or another in the employee's behalf, may obtain emergency treatment at the expense of the employer where such emergency treatment is not provided by the employer.

C. Diagnostic tests shall not be repeated sooner than six (6) months from the date of the test unless agreed to by the parties or ordered by the Commission for good cause shown.

D. Unless recommended by the treating doctor or chiropractor at the time claimant reaches maximum medical improvement or by an independent medical examiner, continuing medical maintenance shall not be awarded by the Commission. The employer or insurance carrier shall not be responsible for continuing medical maintenance or pain management treatment that is outside the parameters established by the ~~Physician Advisory Committee or~~ ODG. The employer or insurance carrier shall not be responsible for continuing medical maintenance or pain management treatment not previously ordered by the

Commission or approved in advance by the employer or insurance carrier.

E. An employee claiming or entitled to benefits under the Administrative Workers' Compensation Act, shall, if ordered by the Commission or requested by the employer or insurance carrier, submit himself or herself for medical examination. If an employee refuses to submit himself or herself to examination, his or her right to prosecute any proceeding under the Administrative Workers' Compensation Act shall be suspended, and no compensation shall be payable for the period of such refusal.

F. For compensable injuries resulting in the use of a medical device, ongoing service for the medical device shall be provided in situations including, but not limited to, medical device battery replacement, ongoing medication refills related to the medical device, medical device repair, or medical device replacement.

G. The employer shall reimburse the employee for the actual mileage in excess of twenty (20) miles round trip to and from the employee's home to the location of a medical service provider for all reasonable and necessary treatment, for an evaluation of an independent medical examiner and for any evaluation made at the request of the employer or insurance carrier. The rate of reimbursement for such travel expense shall be the official reimbursement rate as established by the State Travel Reimbursement

Act. In no event shall the reimbursement of travel for medical treatment or evaluation exceed six hundred (600) miles round trip.

H. Fee Schedule.

1. The Commission shall conduct a review and update of the Current Procedural Terminology (CPT) in the Fee Schedule every two (2) years pursuant to the provisions of paragraph 14 of this subsection. The Fee Schedule shall establish the maximum rates that medical providers shall be reimbursed for medical care provided to injured employees including, but not limited to, charges by physicians, chiropractors, dentists, counselors, hospitals, ambulatory and outpatient facilities, clinical laboratory services, diagnostic testing services, and ambulance services, and charges for durable medical equipment, prosthetics, orthotics, and supplies. The most current Fee Schedule established by the Administrator of the Workers' Compensation Court prior to February 1, 2014, shall remain in effect, unless or until the Legislature approves the Commission's proposed Fee Schedule.

2. Reimbursement for medical care shall be prescribed and limited by the Fee Schedule. The director of the Employees Group Insurance Division of the Office of Management and Enterprise Services shall provide the Commission such information as may be relevant for the development of the Fee Schedule. The Commission shall develop the Fee Schedule in a manner in which quality of medical care is assured and maintained for injured employees. The

Commission shall give due consideration to additional requirements for physicians treating an injured worker under the Administrative Workers' Compensation Act~~,~~ including, but not limited to, communication with claims representatives, case managers, attorneys~~,~~ and representatives of employers, and the additional time required to complete forms for the Commission, insurance carriers, and employers.

3. In making adjustments to the Fee Schedule, the Commission shall use, as a benchmark, the reimbursement rate for each Current Procedural Terminology (CPT) code provided for in the fee schedule published by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services for use in Oklahoma (Medicare Fee Schedule) on the effective date of this section, workers' compensation fee schedules employed by neighboring states, the latest edition of "Relative Values for Physicians" (RVP), usual, customary and reasonable medical payments to workers' compensation health care providers in the same trade area for comparable treatment of a person with similar injuries, and all other data the Commission deems relevant. For services not valued by CMS, the Commission shall establish values based on the usual, customary and reasonable medical payments to health care providers in the same trade area for comparable treatment of a person with similar injuries.

a. No reimbursement shall be allowed for any magnetic resonance imaging (MRI) unless the MRI is provided by an entity that meets Medicare requirements for the payment of MRI services or is accredited by the American College of Radiology, the Intersocietal Accreditation Commission or the Joint Commission on Accreditation of Healthcare Organizations. For all other radiology procedures, the reimbursement rate shall be the lesser of the reimbursement rate allowed by the 2010 Oklahoma Fee Schedule and two hundred seven percent (207%) of the Medicare Fee Schedule.

b. For reimbursement of medical services for Evaluation and Management of injured employees as defined in the Fee Schedule adopted by the Commission, the reimbursement rate shall not be less than one hundred fifty percent (150%) of the Medicare Fee Schedule.

c. Any entity providing durable medical equipment, prosthetics, orthotics or supplies shall be accredited by a CMS-approved accreditation organization. If a physician provides durable medical equipment, prosthetics, orthotics, prescription drugs~~,~~ or supplies to a patient ancillary to the patient's visit, reimbursement shall be no more than ten percent (10%) above cost.

d. The Commission shall develop a reasonable stop-loss provision of the Fee Schedule to provide for adequate reimbursement for treatment for major burns, severe head and neurological injuries, multiple system injuries, and other catastrophic injuries requiring extended periods of intensive care. An employer or insurance carrier shall have the right to audit the charges and question the reasonableness and necessity of medical treatment contained in a bill for treatment covered by the stop-loss provision.

4. The right to recover charges for every type of medical care for injuries arising out of and in the course of covered employment as defined in the Administrative Workers' Compensation Act shall lie solely with the Commission. When a medical care provider has brought a claim to the Commission to obtain payment for services, a party who prevails in full on the claim shall be entitled to reasonable attorney fees.

5. Nothing in this section shall prevent an employer, insurance carrier, group self-insurance association, or certified workplace medical plan from contracting with a provider of medical care for a reimbursement rate that is greater than or less than limits established by the Fee Schedule.

6. A treating physician may not charge more than Four Hundred Dollars ($400.00) per hour for preparation for or testimony at a

deposition or appearance before the Commission in connection with a claim covered by the Administrative Workers' Compensation Act.

7. The Commission's review of medical and treatment charges pursuant to this section shall be conducted pursuant to the Fee Schedule in existence at the time the medical care or treatment was provided. The judgment approving the medical and treatment charges pursuant to this section shall be enforceable by the Commission in the same manner as provided in the Administrative Workers' Compensation Act for the enforcement of other compensation payments.

8. Charges for prescription drugs dispensed by a pharmacy shall be limited to ninety percent (90%) of the average wholesale price of the prescription, plus a dispensing fee of Five Dollars ($5.00) per prescription. "Average wholesale price" means the amount determined from the latest publication designated by the Commission. Physicians shall prescribe and pharmacies shall dispense generic equivalent drugs when available. If the National Drug Code, or "NDC", for the drug product dispensed is for a repackaged drug, then the maximum reimbursement shall be the lesser of the original labeler's NDC and the lowest-cost therapeutic equivalent drug product. Compounded medications shall be billed by the compounding pharmacy at the ingredient level, with each ingredient identified using the applicable NDC of the drug product, and the corresponding quantity. Ingredients with no NDC area are not separately reimbursable. Payment shall be based on a sum of the allowable fee

for each ingredient plus a dispensing fee of Five Dollars ($5.00) per prescription.

9. When medical care includes prescription drugs dispensed by a physician or other medical care provider and the NDC for the drug product dispensed is for a repackaged drug, then the maximum reimbursement shall be the lesser of the original labeler's NDC and the lowest-cost therapeutic equivalent drug product. Payment shall be based upon a sum of the allowable fee for each ingredient plus a dispensing fee of Five Dollars ($5.00) per prescription. Compounded medications shall be billed by the compounding pharmacy.

10. Implantables are paid in addition to procedural reimbursement paid for medical or surgical services. A manufacturer's invoice for the actual cost to a physician, hospital or other entity of an implantable device shall be adjusted by the physician, hospital or other entity to reflect, at the time implanted, all applicable discounts, rebates, considerations and product replacement programs and shall be provided to the payer by the physician or hospital as a condition of payment for the implantable device. If the physician, or an entity in which the physician has a financial interest other than an ownership interest of less than five percent (5%) in a ~~publically~~ publicly traded company, provides implantable devices, this relationship shall be disclosed to patient, employer, insurance company, third-party commission, certified workplace medical plan, case managers~~,~~ and

attorneys representing claimant and defendant. If the physician, or an entity in which the physician has a financial interest other than an ownership interest of less than five percent (5%) in a publicly traded company, buys and resells implantable devices to a hospital or another physician, the markup shall be limited to ten percent (10%) above cost.

11. Payment for medical care as required by the Administrative Workers' Compensation Act shall be due within forty-five (45) days of the receipt by the employer or insurance carrier of a complete and accurate invoice, unless the employer or insurance carrier has a good-faith reason to request additional information about such invoice. Thereafter, the Commission may assess a penalty up to twenty-five percent (25%) for any amount due under the Fee Schedule that remains unpaid on the finding by the Commission that no good-faith reason existed for the delay in payment. If the Commission finds a pattern of an employer or insurance carrier willfully and knowingly delaying payments for medical care, the Commission may assess a civil penalty of not more than Five Thousand Dollars ($5,000.00) per occurrence.

12. If an employee fails to appear for a scheduled appointment with a physician or chiropractor, the employer or insurance company shall pay to the physician or chiropractor a reasonable charge, to be determined by the Commission, for the missed appointment. In the absence of a good-faith reason for missing the appointment, the

Commission shall order the employee to reimburse the employer or insurance company for the charge.

13. Physicians or chiropractors providing treatment under the Administrative Workers' Compensation Act shall disclose under penalty of perjury to the Commission, on a form prescribed by the Commission, any ownership or interest in any health care facility, business, or diagnostic center that is not the physician's or chiropractor's primary place of business. The disclosure shall include any employee leasing arrangement between the physician or chiropractor and any health care facility that is not the physician's or chiropractor's primary place of business. A physician's or chiropractor's failure to disclose as required by this section shall be grounds for the Commission to disqualify the physician or chiropractor from providing treatment under the Administrative Workers' Compensation Act.

14. a. Beginning on May 28, 2019, the Commission shall conduct an evaluation of the Fee Schedule, which shall include an update of the list of Current Procedural Terminology (CPT) codes, a line item adjustment or renewal of all rates, and amendment as needed to the rules applicable to the Fee Schedule.

b. The Commission shall contract with an external consultant with knowledge of workers' compensation fee schedules to review regional and nationwide

comparisons of Oklahoma's Fee Schedule rates and date and market for medical services. The consultant shall receive written and oral comment from employers, workers' compensation medical service and insurance providers, self-insureds, group self-insurance associations of this state and the public. The consultant shall submit a report of its findings and a proposed amended Fee Schedule to the Commission.

c. The Commission shall adopt the proposed amended Fee Schedule in whole or in part and make any additional updates or adjustments. The Commission shall submit a proposed updated and adjusted Fee Schedule to the President Pro Tempore of the Senate, the Speaker of the House of Representatives and the Governor. The proposed Fee Schedule shall become effective on July 1 following the legislative session, if approved by Joint Resolution of the Legislature during the session in which a proposed Fee Schedule is submitted.

d. Beginning on May 28, 2019, an external evaluation shall be conducted and a proposed amended Fee Schedule shall be submitted to the Legislature for approval during the 2020 legislative session. Thereafter, an external evaluation shall be conducted and a proposed

amended Fee Schedule shall be submitted to the Legislature for approval every two (2) years.

I. Formulary. The Commission by rule shall adopt a closed formulary. Rules adopted by the Commission shall allow an appeals process for claims in which a treating doctor determines and documents that a drug not included in the formulary is necessary to treat an injured employee's compensable injury. The Commission by rule shall require the use of generic pharmaceutical medications and clinically appropriate over-the-counter alternatives to prescription medications unless otherwise specified by the prescribing doctor, in accordance with applicable state law.

SECTION 2. REPEALER Section 17, Chapter 208, O.S.L. 2013 (85A O.S. Supp. 2020, Section 17), is hereby repealed.

SECTION 3. REPEALER Section 60, Chapter 208, O.S.L. 2013, as amended by Section 22, Chapter 476, O.S.L. 2019 (85A O.S. Supp. 2020, Section 60), is hereby repealed.

SECTION 4. This act shall become effective November 1, 2021.

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