WEST VIRGINIA CODE: §23-4-3

§23-4-3. Schedule of maximum disbursements for medical, surgical, dental, and hospital treatment; legislative approval; guidelines; preferred provider agreements; charges in excess of scheduled amounts not to be made; required disclosure of financial interest in sale or rental of medically related mechanical appliances or devices; promulgation of rules to enforce requirement; consequences of failure to disclose; contract by employer with hospital, physician, etc., prohibited; criminal penalties for violation; payments to certain providers prohibited; medical cost and care program; payments; interlocutory orders.

(a) The Insurance Commissioner shall establish and alter from time to time, as he or she determines appropriate, a schedule of the maximum reasonable amounts to be paid to health care providers, providers of rehabilitation services, providers of durable medical and other goods, providers of other supplies and medically related items, or other persons, firms, or corporations for the rendering of treatment or services to injured employees under this chapter.

The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall disburse and pay for personal injuries to the employees who are entitled to the benefits under this chapter as follows:

(1) Sums for health care services, rehabilitation services, durable medical and other goods and other supplies, and medically related items as may be reasonably required. The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall determine that which is reasonably required within the meaning of this section in accordance with the medical management rule established by the Insurance Commissioner and approved by the Workers' Compensation Industrial Council pursuant to §23-2C-5 of this code. Each health care provider who seeks to provide services or treatment which are not within any guideline set forth in the rule shall submit to the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, specific justification for the need for the additional services in the particular case and the Insurance Commissioner, private carrier, or self-insured employer shall have the justification reviewed by a health care professional before authorizing the additional services. The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, may enter into preferred provider and managed care agreements which provides for fees and other payments which deviate from the schedule set forth in this subsection.

(2) Payment for health care services, rehabilitation services, durable medical and other goods and other supplies, and medically related items authorized under this subsection may be made to the injured employee or to the person, firm, or corporation who or which has rendered the treatment or furnished health care services, rehabilitation services, durable medical or other goods or other supplies and items, or who has advanced payment for them, as the Insurance Commissioner, private carrier, or self-insured employer, whichever is

applicable, considers proper, but no payments shall be made unless duly verified statements have been filed within six months after the rendering of the treatment or the delivery of such goods, supplies, or items or within 90 days of a subsequent compensability ruling if a claim is initially rejected: *Provided*, That no payment under this section shall be made unless a verified statement shows a charge for the treatment or with respect to any of the items specified in this subdivision has been or will be made against the injured employee or any other person, firm, or corporation. When an employee covered under the provisions of this chapter is injured in the course of and as a result of his or her employment and is accepted for health care services, rehabilitation services, or the provision of durable medical or other goods or other supplies or medically related items, the person, firm, or corporation rendering the treatment may not make any charge or charges for the treatment or with respect to the treatment against the injured employee or any other person, firm, or corporation which would result in a total charge for the treatment rendered in excess of the maximum amount in the fee schedule set forth in this subsection.

(3) Any pharmacist filling a prescription for medication for a workers' compensation claimant shall dispense a generic brand of the prescribed medication if a generic brand exists. If a generic brand does not exist, the pharmacist may dispense the name brand. In the event that a claimant wishes to receive the name brand medication in lieu of the generic brand, the claimant may receive the name brand medication but, in that event, the claimant is personally liable for the difference in costs between the generic brand medication and the brand name medication.

(4) If a claimant elects to receive health care services for a compensable injury from an out-of-state health care provider, and the out-of-state health care provider refuses to accept the rate of reimbursement set forth in the fee schedule established by the Insurance Commissioner, the claimant is personally liable for the difference between the scheduled fee and the amount demanded by the out-of-state health care provider, except as provided in paragraphs (A) or (B) of this subdivision.

(A) In the event of an emergency where there is an urgent need for immediate medical attention in order to prevent the death of a claimant or to prevent serious and permanent harm to the claimant, if the claimant receives the emergency care from an out-of-state health care provider who refuses to accept as full payment the scheduled amount, the claimant is not personally liable for the difference between the amount scheduled and the amount demanded by the health care provider. Upon the claimant's attaining a stable medical condition and being able to be transferred to either a West Virginia health care provider or an out-of-state health care provider who has agreed to accept the scheduled amount of fees as payment in full, if the claimant refuses to seek the specified alternative health care providers, he or she is personally liable for the difference in costs between the scheduled amount and the amount demanded by the health care provider for services provided after attaining stability and being able to be transferred.

(B) In the event that there is no health care provider reasonably near to the claimant's home who is qualified to provide the claimant's needed medical services who is either located in

the State of West Virginia or who has agreed to accept as payment in full the scheduled amounts of fees, the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, upon application by the claimant, may authorize the claimant to receive medical services from another health care provider. The claimant is not personally liable for the difference in costs between the scheduled amount and the amount demanded by the health care provider.

(b)(1) No employer shall enter into any contracts with any hospital, its physicians, officers, agents, or employees to render medical, dental, or hospital service or to give medical or surgical attention to any employee for injury compensable within the purview of this chapter and no employer shall permit or require any employee to contribute, directly or indirectly, to any fund for the payment of such medical, surgical, dental, or hospital service within such hospital for the compensable injury. Any employer violating this subsection is liable in damages to the employer's employees as provided in §23-2-8 of this code, and any employer or hospital or agent or employee thereof violating the provisions of this section is guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine not less than $100 nor more than $1,000 or by imprisonment not exceeding one year, or both.

(2) The provisions of this subsection shall not prohibit an employer, private carrier, or self-insured employer from participating in a managed health care plan, including, but not limited to, a preferred provider organization or program or a health maintenance organization or managed care organization or other medical cost containment relationship with the providers of medical, hospital, or other health care. An employer, private carrier, or self-insured employer that provides a managed health care plan approved by the Insurance Commissioner for its employees or the employees of its insured may require an injured employee to use health care providers authorized by the managed health care plan for care and treatment of his or her compensable injuries. If the employer, private carrier, or self-insured employer does not provide a managed health care plan or program, the claimant may select his or her initial health care provider for treatment of a compensable injury or disease. If a claimant wishes to change his or her health care provider and if his or her employer has established and maintains a managed health care plan, the claimant shall select a new health care provider through the managed health care plan. A claimant who has used the providers under the employer's managed health care plan may select a health care provider outside the employer's plan for treatment of the compensable injury or disease if the employee receives written approval from the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, to do so.

(c) The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall provide for the replacement of artificial limbs, crutches, hearing aids, eyeglasses, and all other mechanical appliances provided in accordance with this section which later wear out, or which later need to be refitted because of the progression of the injury which caused the devices to be originally furnished, or which are broken in the course of and as a result of the employee's employment. The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, shall pay for these devices, when needed, notwithstanding any time limits provided by law.

(d) The Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable, may engage in and contract for medical cost containment programs, pharmacy benefits management programs, medical case management programs, and utilization review programs. Payments for these programs shall be made from the Workers' Compensation Old Fund, by the private carrier, or by the self-insured employer, whichever is applicable. Any order issued pursuant to the program shall be interlocutory in nature until an objecting party has exhausted all review processes provided for by the Insurance Commissioner, private carrier, or self-insured employer, whichever is applicable.

(e) Notwithstanding the provisions of this section, the Insurance Commissioner, private carrier, or self-insured employer may establish fee schedules, make payments, and take other actions required or allowed pursuant to §16-29D-1 *et seq*. of this code.