

LEGISLATURE OF NEBRASKA
ONE HUNDRED FIFTH LEGISLATURE
FIRST SESSION

LEGISLATIVE BILL 609

Introduced by Linehan, 39.

Read first time January 18, 2017

Committee:

- 1 A BILL FOR AN ACT relating to the Nebraska Workers' Compensation Act; to
- 2 amend section 48-125.02, Reissue Revised Statutes of Nebraska, and
- 3 sections 48-120, 48-120.04, and 48-1,110, Revised Statutes
- 4 Cumulative Supplement, 2016; to provide for an outpatient hospital
- 5 fee schedule and ambulatory surgical center fee schedule as
- 6 prescribed; to define terms; to harmonize provisions; and to repeal
- 7 the original sections.
- 8 Be it enacted by the people of the State of Nebraska,

1 Section 1. Section 48-120, Revised Statutes Cumulative Supplement,
2 2016, is amended to read:

3 48-120 (1)(a) The employer is liable for all reasonable medical,
4 surgical, and hospital services, including plastic surgery or
5 reconstructive surgery but not cosmetic surgery when the injury has
6 caused disfigurement, appliances, supplies, prosthetic devices, and
7 medicines as and when needed, which are required by the nature of the
8 injury and which will relieve pain or promote and hasten the employee's
9 restoration to health and employment, and includes damage to or
10 destruction of artificial members, dental appliances, teeth, hearing
11 instruments, and eyeglasses, but, in the case of dental appliances,
12 hearing instruments, or eyeglasses, only if such damage or destruction
13 resulted from an accident which also caused personal injury entitling the
14 employee to compensation therefor for disability or treatment, subject to
15 the approval of and regulation by the Nebraska Workers' Compensation
16 Court, not to exceed the regular charge made for such service in similar
17 cases.

18 (b) Except as provided in section 48-120.04 and sections 3 and 4 of
19 this act, the compensation court shall establish schedules of fees for
20 such services. The compensation court shall review such schedules at
21 least biennially and adopt appropriate changes when necessary. The
22 compensation court may contract with any person, firm, corporation,
23 organization, or government agency to secure adequate data to establish
24 such fees. The compensation court shall publish and furnish to the public
25 the fee schedules established pursuant to this subdivision and section
26 48-120.04 and sections 3 and 4 of this act. The compensation court may
27 establish and charge a fee to recover the cost of published fee
28 schedules.

29 (c) Reimbursement for inpatient hospital services provided by
30 hospitals located in or within fifteen miles of a Nebraska city of the
31 metropolitan class or primary class and by other hospitals with fifty-one

1 or more licensed beds shall be according to the Diagnostic Related Group
2 inpatient hospital fee schedule or the trauma services inpatient hospital
3 fee schedule established in section 48-120.04.

4 (d) Reimbursement for outpatient hospital services provided by
5 hospitals located in or within fifteen miles of a Nebraska city of the
6 metropolitan class or primary class and by other hospitals with fifty-one
7 or more licensed beds shall be according to the outpatient hospital fee
8 schedule established in section 3 of this act.

9 (e) Reimbursement for services provided by ambulatory surgical
10 centers as defined in section 71-405 that have an agreement with the
11 Centers for Medicare and Medicaid Services of the United States
12 Department of Health and Human Services to participate in medicare under
13 Title XVIII of the federal Social Security Act shall be according to the
14 ambulatory surgical center fee schedule established in section 4 of this
15 act.

16 (f) ~~(d)~~ A workers' compensation insurer, risk management pool, self-
17 insured employer, or managed care plan certified pursuant to section
18 48-120.02 may contract with a provider or provider network for medical,
19 surgical, or hospital services. Such contract may establish fees for
20 services different than the fee schedules established under subdivision
21 (1)(b) of this section or established under section 48-120.04 or section
22 3 or 4 of this act. Such contract shall be in writing and mutually agreed
23 upon prior to the date services are provided.

24 (g) ~~(e)~~ The provider or supplier of such services shall not collect
25 or attempt to collect from any employer, insurer, government, or injured
26 employee or dependent or the estate of any injured or deceased employee
27 any amount in excess of (i) the fee established by the compensation court
28 for any such service, (ii) the fee established under section 48-120.04 or
29 section 3 or 4 of this act, or (iii) the fee contracted under subdivision
30 (1)(f) ~~(1)(d)~~ of this section, including any finance charge or late
31 penalty.

1 (2)(a) The employee has the right to select a physician who has
2 maintained the employee's medical records prior to an injury and has a
3 documented history of treatment with the employee prior to an injury or a
4 physician who has maintained the medical records of an immediate family
5 member of the employee prior to an injury and has a documented history of
6 treatment with an immediate family member of the employee prior to an
7 injury. For purposes of this subsection, immediate family member means
8 the employee's spouse, children, parents, stepchildren, and stepparents.
9 The employer shall notify the employee following an injury of such right
10 of selection in a form and manner and within a timeframe established by
11 the compensation court. If the employer fails to notify the employee of
12 such right of selection or fails to notify the employee of such right of
13 selection in a form and manner and within a timeframe established by the
14 compensation court, then the employee has the right to select a
15 physician. If the employee fails to exercise such right of selection in a
16 form and manner and within a timeframe established by the compensation
17 court following notice by the employer pursuant to this subsection, then
18 the employer has the right to select the physician. If selection of the
19 initial physician is made by the employee or employer pursuant to this
20 subsection following notice by the employer pursuant to this subsection,
21 the employee or employer shall not change the initial selection of
22 physician made pursuant to this subsection unless such change is agreed
23 to by the employee and employer or is ordered by the compensation court
24 pursuant to subsection (6) of this section. If compensability is denied
25 by the workers' compensation insurer, risk management pool, or self-
26 insured employer, (i) the employee has the right to select a physician
27 and shall not be made to enter a managed care plan and (ii) the employer
28 is liable for medical, surgical, and hospital services subsequently found
29 to be compensable. If the employer has exercised the right to select a
30 physician pursuant to this subsection and if the compensation court
31 subsequently orders reasonable medical services previously refused to be

1 furnished to the employee by the physician selected by the employer, the
2 compensation court shall allow the employee to select another physician
3 to furnish further medical services. If the employee selects a physician
4 located in a community not the home or place of work of the employee and
5 a physician is available in the local community or in a closer community,
6 no travel expenses shall be required to be paid by the employer or his or
7 her workers' compensation insurer.

8 (b) In cases of injury requiring dismemberment or injuries involving
9 major surgical operation, the employee may designate to his or her
10 employer the physician or surgeon to perform the operation.

11 (c) If the injured employee unreasonably refuses or neglects to
12 avail himself or herself of medical or surgical treatment furnished by
13 the employer, except as herein and otherwise provided, the employer is
14 not liable for an aggravation of such injury due to such refusal and
15 neglect and the compensation court or judge thereof may suspend, reduce,
16 or limit the compensation otherwise payable under the Nebraska Workers'
17 Compensation Act.

18 (d) If, due to the nature of the injury or its occurrence away from
19 the employer's place of business, the employee or the employer is unable
20 to select a physician using the procedures provided by this subsection,
21 the selection requirements of this subsection shall not apply as long as
22 the inability to make a selection persists.

23 (e) The physician selected may arrange for any consultation,
24 referral, or extraordinary or other specialized medical services as the
25 nature of the injury requires.

26 (f) The employer is not responsible for medical services furnished
27 or ordered by any physician or other person selected by the employee in
28 disregard of this section. Except as otherwise provided by the Nebraska
29 Workers' Compensation Act, the employer is not liable for medical,
30 surgical, or hospital services or medicines if the employee refuses to
31 allow them to be furnished by the employer.

1 (3) No claim for such medical treatment is valid and enforceable
2 unless, within fourteen days following the first treatment, the physician
3 giving such treatment furnishes the employer a report of such injury and
4 treatment on a form prescribed by the compensation court. The
5 compensation court may excuse the failure to furnish such report within
6 fourteen days when it finds it to be in the interest of justice to do so.

7 (4) All physicians and other providers of medical services attending
8 injured employees shall comply with all the rules and regulations adopted
9 and promulgated by the compensation court and shall make such reports as
10 may be required by it at any time and at such times as required by it
11 upon the condition or treatment of any injured employee or upon any other
12 matters concerning cases in which they are employed. All medical and
13 hospital information relevant to the particular injury shall, on demand,
14 be made available to the employer, the employee, the workers'
15 compensation insurer, and the compensation court. The party requesting
16 such medical and hospital information shall pay the cost thereof. No such
17 relevant information developed in connection with treatment or
18 examination for which compensation is sought shall be considered a
19 privileged communication for purposes of a workers' compensation claim.
20 When a physician or other provider of medical services willfully fails to
21 make any report required of him or her under this section, the
22 compensation court may order the forfeiture of his or her right to all or
23 part of payment due for services rendered in connection with the
24 particular case.

25 (5) Whenever the compensation court deems it necessary, in order to
26 assist it in resolving any issue of medical fact or opinion, it shall
27 cause the employee to be examined by a physician or physicians selected
28 by the compensation court and obtain from such physician or physicians a
29 report upon the condition or matter which is the subject of inquiry. The
30 compensation court may charge the cost of such examination to the
31 workers' compensation insurer. The cost of such examination shall include

1 the payment to the employee of all necessary and reasonable expenses
2 incident to such examination, such as transportation and loss of wages.

3 (6) The compensation court shall have the authority to determine the
4 necessity, character, and sufficiency of any medical services furnished
5 or to be furnished and shall have authority to order a change of
6 physician, hospital, rehabilitation facility, or other medical services
7 when it deems such change is desirable or necessary. Any dispute
8 regarding medical, surgical, or hospital services furnished or to be
9 furnished under this section may be submitted by the parties, the
10 supplier of such service, or the compensation court on its own motion for
11 informal dispute resolution by a staff member of the compensation court
12 or an outside mediator pursuant to section 48-168. In addition, any party
13 or the compensation court on its own motion may submit such a dispute for
14 a medical finding by an independent medical examiner pursuant to section
15 48-134.01. Issues submitted for informal dispute resolution or for a
16 medical finding by an independent medical examiner may include, but are
17 not limited to, the reasonableness and necessity of any medical treatment
18 previously provided or to be provided to the injured employee. The
19 compensation court may adopt and promulgate rules and regulations
20 regarding informal dispute resolution or the submission of disputes to an
21 independent medical examiner that are considered necessary to effectuate
22 the purposes of this section.

23 (7) For the purpose of this section, physician has the same meaning
24 as in section 48-151.

25 (8) The compensation court shall order the employer to make payment
26 directly to the supplier of any services provided for in this section or
27 reimbursement to anyone who has made any payment to the supplier for
28 services provided in this section. No such supplier or payor may be made
29 or become a party to any action before the compensation court.

30 (9) Notwithstanding any other provision of this section, a workers'
31 compensation insurer, risk management pool, or self-insured employer may

1 contract for medical, surgical, hospital, and rehabilitation services to
2 be provided through a managed care plan certified pursuant to section
3 48-120.02. Once liability for medical, surgical, and hospital services
4 has been accepted or determined, the employer may require that employees
5 subject to the contract receive medical, surgical, and hospital services
6 in the manner prescribed in the contract, except that an employee may
7 receive services from a physician selected by the employee pursuant to
8 subsection (2) of this section if the physician so selected agrees to
9 refer the employee to the managed care plan for any other treatment that
10 the employee may require and if the physician so selected agrees to
11 comply with all the rules, terms, and conditions of the managed care
12 plan. If compensability is denied by the workers' compensation insurer,
13 risk management pool, or self-insured employer, the employee may leave
14 the managed care plan and the employer is liable for medical, surgical,
15 and hospital services previously provided. The workers' compensation
16 insurer, risk management pool, or self-insured employer shall give notice
17 to employees subject to the contract of eligible service providers and
18 such other information regarding the contract and manner of receiving
19 medical, surgical, and hospital services under the managed care plan as
20 the compensation court may prescribe.

21 Sec. 2. Section 48-120.04, Revised Statutes Cumulative Supplement,
22 2016, is amended to read:

23 48-120.04 (1) This section applies only to hospitals identified in
24 subdivision (1)(c) of section 48-120.

25 (2) For inpatient discharges on or after January 1, 2008, the
26 Diagnostic Related Group inpatient hospital fee schedule shall be as set
27 forth in this section, except as otherwise provided in subdivision (1)(f)
28 ~~(1)(d)~~ of section 48-120. Adjustments shall be made annually as provided
29 in this section, with such adjustments to become effective each January
30 1.

31 (3) For inpatient trauma discharges on or after January 1, 2012, the

1 trauma services inpatient hospital fee schedule shall be as set forth in
2 this section, except as otherwise provided in subdivision ~~(1)(f)~~ ~~(1)(d)~~
3 of section 48-120. Adjustments shall be made annually as provided in this
4 section, with such adjustments to become effective each January 1.

5 (4) For purposes of this section:

6 (a) Current Medicare Factor is derived from the Diagnostic Related
7 Group Prospective Payment System as established by the Centers for
8 Medicare and Medicaid Services under the United States Department of
9 Health and Human Services and means the summation of the following
10 components:

11 (i) Hospital-specific Federal Standardized Amount, including all
12 wage index adjustments and reclassifications;

13 (ii) Hospital-specific Capital Standard Federal Rate, including
14 geographic, outlier, and exception adjustment factors;

15 (iii) Hospital-specific Indirect Medical Education Rate, reflecting
16 a percentage add-on for indirect medical education costs and related
17 capital; and

18 (iv) Hospital-specific Disproportionate Share Hospital Rate,
19 reflecting a percentage add-on for disproportionate share of low-income
20 patient costs and related capital;

21 (b) Current Medicare Weight means the weight assigned to each
22 Medicare Diagnostic Related Group as established by the Centers for
23 Medicare and Medicaid Services under the United States Department of
24 Health and Human Services;

25 (c) Diagnostic Related Group means the Diagnostic Related Group
26 assigned to inpatient hospital services using the public domain
27 classification and methodology system developed for the Centers for
28 Medicare and Medicaid Services under the United States Department of
29 Health and Human Services;

30 (d) Trauma means a major single-system or multisystem injury
31 requiring immediate medical or surgical intervention or treatment to

1 prevent death or permanent disability;

2 (e) Workers' Compensation Factor means the Current Medicare Factor
3 for each hospital multiplied by one hundred fifty percent except for
4 inpatient hospital trauma services; and

5 (f) Workers' Compensation Trauma Factor for inpatient hospital
6 trauma services means the Current Medicare Factor for each hospital
7 multiplied by one hundred sixty percent.

8 (5) The Diagnostic Related Group inpatient hospital fee schedule
9 shall include at least thirty-eight of the most frequently utilized
10 Medicare Diagnostic Related Groups for workers' compensation with the
11 goal that the fee schedule covers at least ninety percent of all workers'
12 compensation inpatient hospital claims submitted by hospitals identified
13 in subdivision (1)(c) of section 48-120. Rehabilitation Diagnostic
14 Related Groups shall not be included in the Diagnostic Related Group
15 inpatient hospital fee schedule. Claims for inpatient trauma services
16 shall not be reimbursed under the Diagnostic Related Group inpatient
17 hospital fee schedule established under this section. Claims for
18 inpatient trauma services prior to January 1, 2012, shall be reimbursed
19 under the fees established by the compensation court pursuant to
20 subdivision (1)(b) of section 48-120 or as contracted pursuant to
21 subdivision (1)(f) ~~(1)(d)~~ of such section. Claims for inpatient trauma
22 services on or after January 1, 2012, for Diagnostic Related Groups
23 subject to the Diagnostic Related Group inpatient hospital fee schedule
24 shall be reimbursed under the trauma services inpatient hospital fee
25 schedule established in this section, except as otherwise provided in
26 subdivision (1)(f) ~~(1)(d)~~ of section 48-120.

27 (6) The trauma services inpatient hospital fee schedule shall be
28 established by the following methodology:

29 (a) The trauma services reimbursement amount required under the
30 Nebraska Workers' Compensation Act shall be equal to the Current Medicare
31 Weight multiplied by the Workers' Compensation Trauma Factor for each

1 hospital;

2 (b) The Stop-Loss Threshold amount shall be the trauma services
3 reimbursement amount calculated in subdivision (6)(a) of this section
4 multiplied by one and one-quarter;

5 (c) For charges over the Stop-Loss Threshold amount of the schedule,
6 the hospital shall be reimbursed the trauma services reimbursement amount
7 calculated in subdivision (6)(a) of this section plus sixty-five percent
8 of the charges over the Stop-Loss Threshold amount; and

9 (d) For charges less than the Stop-Loss Threshold amount of the
10 schedule, the hospital shall be reimbursed the lower of the hospital's
11 billed charges or the trauma services reimbursement amount calculated in
12 subdivision (6)(a) of this section.

13 (7) The Diagnostic Related Group inpatient hospital fee schedule
14 shall be established by the following methodology:

15 (a) The Diagnostic Related Group reimbursement amount required under
16 the Nebraska Workers' Compensation Act shall be equal to the Current
17 Medicare Weight multiplied by the Workers' Compensation Factor for each
18 hospital;

19 (b) The Stop-Loss Threshold amount shall be the Diagnostic Related
20 Group reimbursement amount calculated in subdivision (7)(a) of this
21 section multiplied by two and one-half;

22 (c) For charges over the Stop-Loss Threshold amount of the schedule,
23 the hospital shall be reimbursed the Diagnostic Related Group
24 reimbursement amount calculated in subdivision (7)(a) of this section
25 plus sixty percent of the charges over the Stop-Loss Threshold amount;
26 and

27 (d) For charges less than the Stop-Loss Threshold amount of the
28 schedule, the hospital shall be reimbursed the lower of the hospital's
29 billed charges or the Diagnostic Related Group reimbursement amount
30 calculated in subdivision (7)(a) of this section.

31 (8) For charges for all other stays or services that are not

1 reimbursed under the Diagnostic Related Group inpatient hospital fee
2 schedule or the trauma services inpatient hospital fee schedule or are
3 not contracted for under subdivision (1)(f) ~~(1)(d)~~ of section 48-120, the
4 hospital shall be reimbursed under the schedule of fees established by
5 the compensation court pursuant to subdivision (1)(b) of section 48-120.

6 (9) Each hospital shall assign and include a Diagnostic Related
7 Group on each workers' compensation claim submitted. The workers'
8 compensation insurer, risk management pool, or self-insured employer may
9 audit the Diagnostic Related Group assignment of the hospital.

10 (10) The chief executive officer of each hospital shall sign and
11 file with the administrator of the compensation court by October 15 of
12 each year, in the form and manner prescribed by the administrator, a
13 sworn statement disclosing the Current Medicare Factor of the hospital in
14 effect on October 1 of such year and each item and amount making up such
15 factor.

16 (11) Each hospital, workers' compensation insurer, risk management
17 pool, and self-insured employer shall report to the administrator of the
18 compensation court by October 15 of each year, in the form and manner
19 prescribed by the administrator, the total number of claims submitted for
20 each Diagnostic Related Group, the number of claims for each Diagnostic
21 Related Group that included trauma services, the number of times billed
22 charges exceeded the Stop-Loss Threshold amount for each Diagnostic
23 Related Group, and the number of times billed charges exceeded the Stop-
24 Loss Threshold amount for each trauma service.

25 (12) The compensation court may add or subtract Diagnostic Related
26 Groups in striving to achieve the goal of including those Diagnostic
27 Related Groups that encompass at least ninety percent of the inpatient
28 hospital workers' compensation claims submitted by hospitals identified
29 in subdivision (1)(c) of section 48-120. The administrator of the
30 compensation court shall annually make necessary adjustments to comply
31 with the Current Medicare Weights and shall annually adjust the Current

1 Medicare Factor for each hospital based on the annual statement submitted
2 pursuant to subsection (10) of this section.

3 Sec. 3. (1) This section applies only to hospitals identified in
4 subdivision (1)(d) of section 48-120.

5 (2) For outpatient hospital discharges on or after January 1, 2018,
6 the Outpatient Prospective Payment System developed by the Centers for
7 Medicare and Medicaid Services for payment of outpatient hospital
8 services shall be as set forth in this section, except as otherwise
9 provided in subdivision (1)(f) of section 48-120. Adjustments shall be
10 made annually as provided in this section, with such adjustments to
11 become effective each January 1.

12 (3) For purposes of this section:

13 (a) HCPCS Code is the procedure, article, supply, or service
14 reported by the hospital;

15 (b) National Correct Coding Initiative or NCCI means the policies
16 and procedures set forth in the National Correct Coding Initiative Policy
17 Manual for Medicare Services and all corresponding tables, as
18 established, updated, and implemented by Medicare to determine correct
19 coding methodologies for the reporting of services, including the
20 following components:

21 (i) Procedure-to-Procedure edits;

22 (ii) Medically Unlikely Edits; and

23 (iii) Add-on Code Edits.

24 (c)(i) Outpatient Prospective Payment System or OPPS means the
25 hospital outpatient prospective payment system specified in:

26 (A) 42 C.F.R. part 419;

27 (B) Annual revisions to the rules described in subdivision (3)(c)(i)
28 (A) of this section as published in the Federal Register;

29 (C) The corresponding Addendum B (Final OPPS Payment by HCPCS code),
30 Addendum D1 (Payment Indicators), and any successor or replacement
31 addenda; and

1 (D) The Medicare Claims Processing Manual; and
2 (ii) Outpatient Prospective Payment System does not include Addendum
3 A (Final OPSS APCs); and

4 (d) Payment Indicator means the status assigned to each HCPCS Code
5 identified in Addendum B for determining reimbursement or processing and
6 as defined in Addendum D1.

7 (4) Payment for covered surgical procedures and ancillary services
8 based on the OPSS will conform to the following methodology:

9 (a) Payment to the hospital for covered services and ancillary
10 services for compensable treatment shall be paid according to the lesser
11 of:

12 (i) The hospital's billed charges for all services, supplies, and
13 implantable devices provided; or

14 (ii) The Medicare OPSS payment listed in Addendum B times XXX
15 percent;

16 (b) Payment according to status indicators shall be paid according
17 to the following conditions:

18 (i) HCPCS Codes assigned a Status Indicator A, M, and Q4 are paid
19 according to the Nebraska Workers' Compensation Court medical services
20 fee schedule pursuant to section 48-120;

21 (ii) HCPCS Codes assigned a Status Indicator B are not paid under
22 OPSS if billed with a Bill Type 12X or 13X. Hospitals shall resubmit
23 under a separate bill type or using a different HCPCS Code if one exists;

24 (iii) HCPCS Codes assigned a Status Indicator C reflect inpatient
25 only procedures and are not payable on an outpatient basis;

26 (iv) HCPCS Codes assigned a Status Indicator J1 are outlined
27 according to the following conditions:

28 (A) Only HCPCS Codes assigned a Status Indicator F, G, H, or U are
29 paid separately; and

30 (B) If more than one HCPCS Code is assigned a Status Indicator J1,
31 then the highest paid HCPCS Code assigned a Status Indicator J1 is paid

1 according to subdivision (4)(a) of this section, and subsequent HCPCS
2 Codes assigned a Status Indicator J1 are reimbursed at sixty-five percent
3 of the amount calculated in subdivision (4)(a) of this section to reflect
4 the complexity adjustment;

5 (v) HCPCS Codes assigned a Status Indicator starting with E or L are
6 not paid or covered under the Workers' Compensation System;

7 (vi) Any HCPCS Code assigned a Status Indicator F, H, P, U, or Y are
8 paid at seventy percent of the hospital's billed charges;

9 (vii) HCPCS Codes assigned a Status Indicator N are bundled and are
10 not separately paid;

11 (viii) HCPCS Codes assigned a Status Indicator Q1 are bundled into
12 any HCPCS Code assigned a Status Indicator S, T, or V and are not
13 separately paid;

14 (ix) HCPCS Codes assigned a Status Indicator Q2 are bundled into any
15 HCPCS Code assigned a Status Indicator T and are not separately paid; and

16 (x) HCPCS Codes assigned a Status Indicator starting with G, J2, K,
17 Q3, R, S, or V are paid according to subdivision (4)(a) of this section;

18 (c) Revenue codes billed without any HCPCS Codes are packaged into
19 the payable services on that bill and are not separately payable or
20 subject to the outlier provisions; and

21 (d) When more than one HCPCS Code assigned a Status Indicator
22 starting with T is billed, the Multiple Surgical Procedure Reduction Rule
23 applies, whereby the service with the highest OPPS payment is paid
24 according to subdivision (4)(a) of this section with all subsequent
25 services assigned a Status Indicator starting with T reduced by fifty
26 percent.

27 (5) Outliers for outpatient hospital services are based on a service
28 basis, excluding HCPCS Codes assigned a Status Indicator G or K, and are
29 only allowed for a code that is separately payable under subsection (4)
30 of this section. The outlier payment shall be the Fixed Dollar Threshold,
31 published under the Outlier Thresholds and Payment Percentage through the

1 Centers for Medicare and Medicaid Services, for each calendar year based
2 on the year of the date of service. Adjustments shall be made annually as
3 provided in this section, with such adjustments to become effective each
4 January 1. Outlier payments will be determined according to the
5 following:

6 (a) The Stop-Loss Threshold amount shall be the reimbursement
7 calculated in subsection (4) of this section plus the Fixed Dollar
8 Threshold; and

9 (b) For charges over the Stop-Loss amount of the schedule, the
10 hospital shall be reimbursed the OPPS amount calculated in subsection (4)
11 of this section plus sixty percent of the charges over the Stop-Loss
12 Threshold.

13 (6) Hospitals must bill workers' compensation insurers using the
14 same codes, formats, and details that are required for billing the
15 Medicare program, including coding consistent with the OPPS, the American
16 Medical Association CPT Coding Guidelines, and the National Correct
17 Coding Initiative edits.

18 Sec. 4. (1) This section applies only to ambulatory surgical
19 centers as defined in section 71-405.

20 (2) For ambulatory surgical center discharges on or after January 1,
21 2018, the Ambulatory Surgical Center Payment System developed by the
22 Centers for Medicare and Medicaid Services for payment of surgical
23 services provided by federally certified ambulatory surgical centers
24 shall be as set forth in this section, except as otherwise provided in
25 subdivision (1)(f) of section 48-120. Adjustments shall be made annually
26 as provided in this section, with such adjustments to become effective
27 each January 1.

28 (3) For purposes of this section:

29 (a) Ambulatory Surgical Center Payment System or ASCPS means the
30 system specified in:

31 (i) 42 C.F.R. part 416;

1 (ii) Annual revisions to the rules described in subdivision (3)(a)
2 (i) of this section as published in the Federal Register;

3 (iii) The corresponding Addendum AA (Final ASC Covered Surgical
4 Procedures), Addendum BB (Final ASC Covered Ancillary Services Integral
5 to Covered Surgical Procedures), Addendum DD1 (Final ASC Payment
6 Indicators), and any successor or replacement addenda; and

7 (iv) The Medicare Claims Processing Manual;

8 (b) HCPCS Code is the procedure, article, supply, or service
9 reported by the ambulatory surgical center;

10 (c) National Correct Coding Initiative or NCCI means the policies
11 and procedures set forth in the National Correct Coding Initiative Policy
12 Manual for Medicare Services and all corresponding tables, as
13 established, updated, and implemented by Medicare to determine correct
14 coding methodologies for the reporting of services, including the
15 following components:

16 (i) Procedure-to-Procedure edits;

17 (ii) Medically Unlikely Edits; and

18 (iii) Add-on Code Edits; and

19 (d) Payment Indicator means the status assigned to each HCPCS Code
20 identified in Addendum AA and Addendum BB for determining reimbursement
21 or processing and as defined in Addendum DD1.

22 (4) Payment for covered surgical procedures and ancillary services
23 based on the ASCPS will conform to the following methodology:

24 (a) Payment to the ambulatory surgical center for covered surgical
25 procedures and ancillary services for compensable treatment shall be paid
26 according to the lesser of:

27 (i) The ambulatory surgical center's billed charges for all
28 services, supplies, and implantable devices provided; or

29 (ii) The Medicare ASCPS payment listed in Addendum AA and Addendum
30 BB times XXX percent;

31 (b) When more than one surgical procedure is performed, the Multiple

1 Surgical Procedure Reduction Rule applies, whereby the surgical service
2 with the highest ASCPS payment is paid according to subdivision (4)(a) of
3 this section with all subsequent surgical services reduced by fifty
4 percent;

5 (c) Services with a payment indicator advising services are paid
6 separately when provided integral to a surgical procedure by the
7 ambulatory surgical center are not subject to the Multiple Surgical
8 Procedure Reduction Rule; and

9 (d) Payment must be made at seventy percent of the ambulatory
10 surgical center's billed charges for a surgical procedure or ancillary
11 service if the procedure or service has a payment status indicator
12 advising that payment is made according to the following conditions:

13 (i) Paid at reasonable cost; or

14 (ii) Payment contractor-priced.

15 (5) Ambulatory surgical centers must bill workers' compensation
16 insurers using the same codes, formats, and details that are required for
17 billing the Medicare program, including coding consistent with the ASCPS,
18 the American Medical Association CPT Coding Guidelines, and the National
19 Correct Coding Initiative edits.

20 Sec. 5. Section 48-125.02, Reissue Revised Statutes of Nebraska, is
21 amended to read:

22 48-125.02 (1) Regarding payment of a claim for medical, surgical, or
23 hospital services for a state employee under the Nebraska Workers'
24 Compensation Act, the Prompt Payment Act applies.

25 (2) For claims other than claims under subsection (1) of this
26 section regarding payment of a claim for medical, surgical, or hospital
27 services for an employee under the Nebraska Workers' Compensation Act:

28 (a) The workers' compensation insurer, risk management pool, or
29 self-insured employer shall notify the provider within fifteen business
30 days after receiving a claim as to what information is necessary to
31 process the claim. Failure to notify the provider assumes the workers'

1 compensation insurer, risk management pool, or self-insured employer has
2 all information necessary to pay the claim. The workers' compensation
3 insurer, risk management pool, or self-insured employer shall pay
4 providers in accordance with sections 48-120 and 48-120.04 and sections 3
5 and 4 of this act within thirty business days after receipt of all
6 information necessary to process the claim. Failure to pay the provider
7 within the thirty days will cause the workers' compensation insurer, risk
8 management pool, or self-insured employer to reimburse the provider's
9 billed charges instead of the scheduled or contracted fees;

10 (b) If a claim is submitted electronically, the claim is presumed to
11 have been received on the date of the electronic verification of receipt
12 by the workers' compensation insurer, risk management pool, or self-
13 insured employer or its clearinghouse. If a claim is submitted by mail,
14 the claim is presumed to have been received five business days after the
15 claim has been placed in the United States mail with first-class postage
16 prepaid. The presumption may be rebutted by sufficient evidence that the
17 claim was received on another day or not received at all; and

18 (c) Payment of a claim by the workers' compensation insurer, risk
19 management pool, or self-insured employer means the receipt of funds by
20 the provider. If payment is submitted electronically, the payment is
21 presumed to have been received on the date of the electronic verification
22 of receipt by the provider or the provider's clearinghouse. If payment is
23 submitted by mail, the payment is presumed to have been received five
24 business days after the payment has been placed in the United States mail
25 with first-class postage prepaid. The presumption may be rebutted by
26 sufficient evidence that the payment was received on another day or not
27 received at all.

28 Sec. 6. Section 48-1,110, Revised Statutes Cumulative Supplement,
29 2016, is amended to read:

30 48-1,110 Sections 48-101 to 48-1,117 and sections 3 and 4 of this
31 act shall be known and may be cited as the Nebraska Workers' Compensation

1 Act.

2 Sec. 7. Original section 48-125.02, Reissue Revised Statutes of
3 Nebraska, and sections 48-120, 48-120.04, and 48-1,110, Revised Statutes
4 Cumulative Supplement, 2016, are repealed.