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LEGISLATURE OF NEBRASKA

ONE HUNDRED FIFTH LEGISLATURE

FIRST SESSION

# LEGISLATIVE BILL 609

Introduced by Linehan, 39.

Read first time January 18, 2017

Committee: Business and Labor

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

Be it enacted by the people of the State of Nebraska,

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

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

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

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

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

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

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

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

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

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(2)(a) The employee has the right to select a physician who has maintained the employee's medical records prior to an injury and has a documented history of treatment with the employee prior to an injury or a physician who has maintained the medical records of an immediate family member of the employee prior to an injury and has a documented history of treatment with an immediate family member of the employee prior to an injury. For purposes of this subsection, immediate family member means the employee's spouse, children, parents, stepchildren, and stepparents. The employer shall notify the employee following an injury of such right of selection in a form and manner and within a timeframe established by the compensation court. If the employer fails to notify the employee of such right of selection or fails to notify the employee of such right of selection in a form and manner and within a timeframe established by the compensation court, then the employee has the right to select a physician. If the employee fails to exercise such right of selection in a form and manner and within a timeframe established by the compensation court following notice by the employer pursuant to this subsection, then the employer has the right to select the physician. If selection of the initial physician is made by the employee or employer pursuant to this subsection following notice by the employer pursuant to this subsection, the employee or employer shall not change the initial selection of physician made pursuant to this subsection unless such change is agreed to by the employee and employer or is ordered by the compensation court pursuant to subsection (6) of this section. If compensability is denied by the workers' compensation insurer, risk management pool, or self-insured employer, (i) the employee has the right to select a physician and shall not be made to enter a managed care plan and (ii) the employer is liable for medical, surgical, and hospital services subsequently found to be compensable. If the employer has exercised the right to select a physician pursuant to this subsection and if the compensation court subsequently orders reasonable medical services previously refused to be

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) For purposes of this section:

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

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

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

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

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

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

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

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

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prevent death or permanent disability;

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

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

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

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

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

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hospital;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) For purposes of this section:

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

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

(i) Procedure-to-Procedure edits;

(ii) Medically Unlikely Edits; and

(iii) Add-on Code Edits.

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

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

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

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

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(D) The Medicare Claims Processing Manual; and

(ii) Outpatient Prospective Payment System does not include Addendum A (Final OPPS APCs); and

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

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

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

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

(ii) The Medicare OPPS payment listed in Addendum B times XXX percent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) For purposes of this section:

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

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

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

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

(iv) The Medicare Claims Processing Manual;

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

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

(i) Procedure-to-Procedure edits;

(ii) Medically Unlikely Edits; and

(iii) Add-on Code Edits; and

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

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

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

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

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

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

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

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

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

(i) Paid at reasonable cost; or

(ii) Payment contractor-priced.

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

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

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

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

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

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

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

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

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

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

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Act.

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