



January 23, 2015

SENATE BILL No. 33

DIGEST OF SB 33 (Updated January 21, 2015 12:31 pm - DI 102)

Citations Affected: IC 22-3.

Synopsis: Worker's compensation. Adds an ambulatory outpatient surgical center to the definition of "medical service facility" under the worker's compensation law. Provides that payment for an implant to an ambulatory outpatient surgical center that is not otherwise reimbursed for the implant is equal to 125% of the implant's cost as evidenced by the invoice amount.

Effective: July 1, 2015.

Boots

January 6, 2015, read first time and referred to Committee on Pensions & Labor.
January 22, 2015, amended, reported favorably — Do Pass.

SB 33—LS 6150/DI 102



January 23, 2015

First Regular Session 119th General Assembly (2015)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 2014 Regular Session and 2014 Second Regular Technical Session of the General Assembly.

SENATE BILL No. 33

A BILL FOR AN ACT to amend the Indiana Code concerning labor and safety.

Be it enacted by the General Assembly of the State of Indiana:

1 SECTION 1. IC 22-3-3-5.2, AS AMENDED BY P.L.99-2014,
2 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
3 JULY 1, 2015]: Sec. 5.2. (a) A billing review service shall adhere to
4 the following requirements to determine the pecuniary liability of an
5 employer or an employer's insurance carrier for a specific service or
6 product covered under worker's compensation provided before July 1,
7 2014, by all medical service providers, and after June 30, 2014, by a
8 medical service provider that is not a medical service facility:
9 (1) The formation of a billing review standard, and any
10 subsequent analysis or revision of the standard, must use data that
11 is based on the medical service provider billing charges as
12 submitted to the employer and the employer's insurance carrier
13 from the same community. This subdivision does not apply when
14 a unique or specialized service or product does not have sufficient
15 comparative data to allow for a reasonable comparison.
16 (2) Data used to determine pecuniary liability must be compiled

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1 on or before June 30 and December 31 of each year.

2 (3) Billing review standards must be revised for prospective
3 future payments of medical service provider bills to provide for
4 payment of the charges at a rate not more than the charges made
5 by eighty percent (80%) of the medical service providers during
6 the prior six (6) months within the same community. The data
7 used to perform the analysis and revision of the billing review
8 standards may not be more than two (2) years old and must be
9 periodically updated by a representative inflationary or
10 deflationary factor. Reimbursement for these charges may not
11 exceed the actual charge invoiced by the medical service
12 provider.

13 (b) This subsection applies after June 30, 2014, to a medical service
14 facility. The pecuniary liability of an employer or an employer's
15 insurance carrier for a specific service or product covered under
16 worker's compensation and provided by a medical service facility is
17 equal to a reasonable amount, which is established by payment of one
18 (1) of the following:

19 (1) The amount negotiated at any time between the medical
20 service facility and any of the following:

21 (A) The employer.

22 (B) The employer's insurance carrier.

23 (C) A billing review service on behalf of a person described in
24 clause (A) or (B).

25 (D) A direct provider network that has contracted with a
26 person described in clause (A) or (B).

27 (2) Two hundred percent (200%) of the amount that would be
28 paid to the medical service facility on the same date for the same
29 service or product under the medical service facility's Medicare
30 reimbursement rate, if an amount has not been negotiated as
31 described in subdivision (1).

32 (c) **This subsection applies to a medical service facility that is:**

33 (1) **an ambulatory outpatient surgical center (as defined in**
34 **IC 16-18-2-14); and**

35 (2) **not reimbursed for an implant under subsection (b).**

36 **Payment for an implant furnished to an employee under IC 22-3-2**
37 **through IC 22-3-6 is equal to one hundred twenty-five percent**
38 **(125%) of the implant's cost as evidenced by the invoice amount.**

39 (e) (d) A medical service provider may request an explanation from
40 a billing review service if the medical service provider's bill has been
41 reduced as a result of application of the eightieth percentile or of a
42 Current Procedural Terminology (CPT) or Medicare coding change.



1 The request must be made not later than sixty (60) days after receipt of
 2 the notice of the reduction. If a request is made, the billing review
 3 service must provide:

- 4 (1) the name of the billing review service used to make the
 5 reduction;
- 6 (2) the dollar amount of the reduction;
- 7 (3) the dollar amount of the service or product at the eightieth
 8 percentile; and
- 9 (4) in the case of a CPT or Medicare coding change, the basis
 10 upon which the change was made;

11 not later than thirty (30) days after the date of the request.

12 ~~(d)~~ (e) If, after a hearing, the worker's compensation board finds that
 13 a billing review service used a billing review standard that did not
 14 comply with subsection (a)(1) through (a)(3), as applicable, in
 15 determining the pecuniary liability of an employer or an employer's
 16 insurance carrier for a medical service provider's charge for services or
 17 products covered under worker's compensation, the worker's
 18 compensation board may assess a civil penalty against the billing
 19 review service in an amount not less than one hundred dollars (\$100)
 20 and not more than one thousand dollars (\$1,000).

21 SECTION 2. IC 22-3-6-1, AS AMENDED BY P.L.99-2014,
 22 SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 23 JULY 1, 2015]: Sec. 1. In IC 22-3-2 through IC 22-3-6, unless the
 24 context otherwise requires:

25 (a) "Employer" includes the state and any political subdivision, any
 26 municipal corporation within the state, any individual or the legal
 27 representative of a deceased individual, firm, association, limited
 28 liability company, or corporation or the receiver or trustee of the same,
 29 using the services of another for pay. A parent corporation and its
 30 subsidiaries shall each be considered joint employers of the
 31 corporation's, the parent's, or the subsidiaries' employees for purposes
 32 of IC 22-3-2-6 and IC 22-3-3-31. Both a lessor and a lessee of
 33 employees shall each be considered joint employers of the employees
 34 provided by the lessor to the lessee for purposes of IC 22-3-2-6 and
 35 IC 22-3-3-31. If the employer is insured, the term includes the
 36 employer's insurer so far as applicable. However, the inclusion of an
 37 employer's insurer within this definition does not allow an employer's
 38 insurer to avoid payment for services rendered to an employee with the
 39 approval of the employer. The term also includes an employer that
 40 provides on-the-job training under the federal School to Work
 41 Opportunities Act (20 U.S.C. 6101 et seq.) to the extent set forth in
 42 IC 22-3-2-2.5. The term does not include a nonprofit corporation that



1 is recognized as tax exempt under Section 501(c)(3) of the Internal
2 Revenue Code (as defined in IC 6-3-1-11(a)) to the extent the
3 corporation enters into an independent contractor agreement with a
4 person for the performance of youth coaching services on a part-time
5 basis.

6 (b) "Employee" means every person, including a minor, in the
7 service of another, under any contract of hire or apprenticeship, written
8 or implied, except one whose employment is both casual and not in the
9 usual course of the trade, business, occupation, or profession of the
10 employer.

11 (1) An executive officer elected or appointed and empowered in
12 accordance with the charter and bylaws of a corporation, other
13 than a municipal corporation or governmental subdivision or a
14 charitable, religious, educational, or other nonprofit corporation,
15 is an employee of the corporation under IC 22-3-2 through
16 IC 22-3-6. An officer of a corporation who is an employee of the
17 corporation under IC 22-3-2 through IC 22-3-6 may elect not to
18 be an employee of the corporation under IC 22-3-2 through
19 IC 22-3-6. If an officer makes this election, the officer must serve
20 written notice of the election on the corporation's insurance
21 carrier and the board. An officer of a corporation may not be
22 considered to be excluded as an employee under IC 22-3-2
23 through IC 22-3-6 until the notice is received by the insurance
24 carrier and the board.

25 (2) An executive officer of a municipal corporation or other
26 governmental subdivision or of a charitable, religious,
27 educational, or other nonprofit corporation may, notwithstanding
28 any other provision of IC 22-3-2 through IC 22-3-6, be brought
29 within the coverage of its insurance contract by the corporation by
30 specifically including the executive officer in the contract of
31 insurance. The election to bring the executive officer within the
32 coverage shall continue for the period the contract of insurance is
33 in effect, and during this period, the executive officers thus
34 brought within the coverage of the insurance contract are
35 employees of the corporation under IC 22-3-2 through IC 22-3-6.

36 (3) Any reference to an employee who has been injured, when the
37 employee is dead, also includes the employee's legal
38 representatives, dependents, and other persons to whom
39 compensation may be payable.

40 (4) An owner of a sole proprietorship may elect to include the
41 owner as an employee under IC 22-3-2 through IC 22-3-6 if the
42 owner is actually engaged in the proprietorship business. If the



1 owner makes this election, the owner must serve upon the owner's
 2 insurance carrier and upon the board written notice of the
 3 election. No owner of a sole proprietorship may be considered an
 4 employee under IC 22-3-2 through IC 22-3-6 until the notice has
 5 been received. If the owner of a sole proprietorship:

6 (A) is an independent contractor in the construction trades and
 7 does not make the election provided under this subdivision,
 8 the owner must obtain a certificate of exemption under
 9 IC 22-3-2-14.5; or

10 (B) is an independent contractor and does not make the
 11 election provided under this subdivision, the owner may obtain
 12 a certificate of exemption under IC 22-3-2-14.5.

13 (5) A partner in a partnership may elect to include the partner as
 14 an employee under IC 22-3-2 through IC 22-3-6 if the partner is
 15 actually engaged in the partnership business. If a partner makes
 16 this election, the partner must serve upon the partner's insurance
 17 carrier and upon the board written notice of the election. No
 18 partner may be considered an employee under IC 22-3-2 through
 19 IC 22-3-6 until the notice has been received. If a partner in a
 20 partnership:

21 (A) is an independent contractor in the construction trades and
 22 does not make the election provided under this subdivision,
 23 the partner must obtain a certificate of exemption under
 24 IC 22-3-2-14.5; or

25 (B) is an independent contractor and does not make the
 26 election provided under this subdivision, the partner may
 27 obtain a certificate of exemption under IC 22-3-2-14.5.

28 (6) Real estate professionals are not employees under IC 22-3-2
 29 through IC 22-3-6 if:

30 (A) they are licensed real estate agents;

31 (B) substantially all their remuneration is directly related to
 32 sales volume and not the number of hours worked; and

33 (C) they have written agreements with real estate brokers
 34 stating that they are not to be treated as employees for tax
 35 purposes.

36 (7) A person is an independent contractor and not an employee
 37 under IC 22-3-2 through IC 22-3-6 if the person is an independent
 38 contractor under the guidelines of the United States Internal
 39 Revenue Service.

40 (8) An owner-operator that provides a motor vehicle and the
 41 services of a driver under a written contract that is subject to
 42 IC 8-2.1-24-23, 45 IAC 16-1-13, or 49 CFR 376 to a motor carrier



1 is not an employee of the motor carrier for purposes of IC 22-3-2
 2 through IC 22-3-6. The owner-operator may elect to be covered
 3 and have the owner-operator's drivers covered under a worker's
 4 compensation insurance policy or authorized self-insurance that
 5 insures the motor carrier if the owner-operator pays the premiums
 6 as requested by the motor carrier. An election by an
 7 owner-operator under this subdivision does not terminate the
 8 independent contractor status of the owner-operator for any
 9 purpose other than the purpose of this subdivision.

10 (9) A member or manager in a limited liability company may elect
 11 to include the member or manager as an employee under
 12 IC 22-3-2 through IC 22-3-6 if the member or manager is actually
 13 engaged in the limited liability company business. If a member or
 14 manager makes this election, the member or manager must serve
 15 upon the member's or manager's insurance carrier and upon the
 16 board written notice of the election. A member or manager may
 17 not be considered an employee under IC 22-3-2 through IC 22-3-6
 18 until the notice has been received.

19 (10) An unpaid participant under the federal School to Work
 20 Opportunities Act (20 U.S.C. 6101 et seq.) is an employee to the
 21 extent set forth in IC 22-3-2-2.5.

22 (11) A person who enters into an independent contractor
 23 agreement with a nonprofit corporation that is recognized as tax
 24 exempt under Section 501(c)(3) of the Internal Revenue Code (as
 25 defined in IC 6-3-1-11(a)) to perform youth coaching services on
 26 a part-time basis is not an employee for purposes of IC 22-3-2
 27 through IC 22-3-6.

28 (12) An individual who is not an employee of the state or a
 29 political subdivision is considered to be a temporary employee of
 30 the state for purposes of IC 22-3-2 through IC 22-3-6 while
 31 serving as a member of a mobile support unit on duty for training,
 32 an exercise, or a response, as set forth in IC 10-14-3-19(c)(2)(B).

33 (c) "Minor" means an individual who has not reached seventeen
 34 (17) years of age.

35 (1) Unless otherwise provided in this subsection, a minor
 36 employee shall be considered as being of full age for all purposes
 37 of IC 22-3-2 through IC 22-3-6.

38 (2) If the employee is a minor who, at the time of the accident, is
 39 employed, required, suffered, or permitted to work in violation of
 40 IC 20-33-3-35, the amount of compensation and death benefits,
 41 as provided in IC 22-3-2 through IC 22-3-6, shall be double the
 42 amount which would otherwise be recoverable. The insurance



1 carrier shall be liable on its policy for one-half (1/2) of the
 2 compensation or benefits that may be payable on account of the
 3 injury or death of the minor, and the employer shall be liable for
 4 the other one-half (1/2) of the compensation or benefits. If the
 5 employee is a minor who is not less than sixteen (16) years of age
 6 and who has not reached seventeen (17) years of age and who at
 7 the time of the accident is employed, suffered, or permitted to
 8 work at any occupation which is not prohibited by law, this
 9 subdivision does not apply.

10 (3) A minor employee who, at the time of the accident, is a
 11 student performing services for an employer as part of an
 12 approved program under IC 20-37-2-7 shall be considered a
 13 full-time employee for the purpose of computing compensation
 14 for permanent impairment under IC 22-3-3-10. The average
 15 weekly wages for such a student shall be calculated as provided
 16 in subsection (d)(4).

17 (4) The rights and remedies granted in this subsection to a minor
 18 under IC 22-3-2 through IC 22-3-6 on account of personal injury
 19 or death by accident shall exclude all rights and remedies of the
 20 minor, the minor's parents, or the minor's personal
 21 representatives, dependents, or next of kin at common law,
 22 statutory or otherwise, on account of the injury or death. This
 23 subsection does not apply to minors who have reached seventeen
 24 (17) years of age.

25 (d) "Average weekly wages" means the earnings of the injured
 26 employee in the employment in which the employee was working at the
 27 time of the injury during the period of fifty-two (52) weeks
 28 immediately preceding the date of injury, divided by fifty-two (52),
 29 except as follows:

30 (1) If the injured employee lost seven (7) or more calendar days
 31 during this period, although not in the same week, then the
 32 earnings for the remainder of the fifty-two (52) weeks shall be
 33 divided by the number of weeks and parts thereof remaining after
 34 the time lost has been deducted.

35 (2) Where the employment prior to the injury extended over a
 36 period of less than fifty-two (52) weeks, the method of dividing
 37 the earnings during that period by the number of weeks and parts
 38 thereof during which the employee earned wages shall be
 39 followed, if results just and fair to both parties will be obtained.
 40 Where by reason of the shortness of the time during which the
 41 employee has been in the employment of the employee's employer
 42 or of the casual nature or terms of the employment it is



1 impracticable to compute the average weekly wages, as defined
 2 in this subsection, regard shall be had to the average weekly
 3 amount which during the fifty-two (52) weeks previous to the
 4 injury was being earned by a person in the same grade employed
 5 at the same work by the same employer or, if there is no person so
 6 employed, by a person in the same grade employed in the same
 7 class of employment in the same district.

8 (3) Wherever allowances of any character made to an employee
 9 in lieu of wages are a specified part of the wage contract, they
 10 shall be deemed a part of the employee's earnings.

11 (4) In computing the average weekly wages to be used in
 12 calculating an award for permanent impairment under
 13 IC 22-3-3-10 for a student employee in an approved training
 14 program under IC 20-37-2-7, the following formula shall be used.
 15 Calculate the product of:

- 16 (A) the student employee's hourly wage rate; multiplied by
- 17 (B) forty (40) hours.

18 The result obtained is the amount of the average weekly wages for
 19 the student employee.

20 (e) "Injury" and "personal injury" mean only injury by accident
 21 arising out of and in the course of the employment and do not include
 22 a disease in any form except as it results from the injury.

23 (f) "Billing review service" refers to a person or an entity that
 24 reviews a medical service provider's bills or statements for the purpose
 25 of determining pecuniary liability. The term includes an employer's
 26 worker's compensation insurance carrier if the insurance carrier
 27 performs such a review.

28 (g) "Billing review standard" means the data used by a billing
 29 review service to determine pecuniary liability.

30 (h) "Community" means a geographic service area based on ZIP
 31 code districts defined by the United States Postal Service according to
 32 the following groupings:

- 33 (1) The geographic service area served by ZIP codes with the first
 34 three (3) digits 463 and 464.
- 35 (2) The geographic service area served by ZIP codes with the first
 36 three (3) digits 465 and 466.
- 37 (3) The geographic service area served by ZIP codes with the first
 38 three (3) digits 467 and 468.
- 39 (4) The geographic service area served by ZIP codes with the first
 40 three (3) digits 469 and 479.
- 41 (5) The geographic service area served by ZIP codes with the first
 42 three (3) digits 460, 461 (except 46107), and 473.



- 1 (6) The geographic service area served by the 46107 ZIP code and
 2 ZIP codes with the first three (3) digits 462.
 3 (7) The geographic service area served by ZIP codes with the first
 4 three (3) digits 470, 471, 472, 474, and 478.
 5 (8) The geographic service area served by ZIP codes with the first
 6 three (3) digits 475, 476, and 477.
 7 (i) "Medical service provider" refers to a person or an entity that
 8 provides services or products to an employee under IC 22-3-2 through
 9 IC 22-3-6. Except as otherwise provided in IC 22-3-2 through
 10 IC 22-3-6, the term includes a medical service facility.
 11 (j) "Medical service facility" means any of the following that
 12 provides a service or product under IC 22-3-2 through IC 22-3-6 and
 13 uses **or would be required to use** the CMS 1450 (UB-04) form for
 14 Medicare reimbursement:
 15 **(1) An ambulatory outpatient surgical center (as defined in**
 16 **IC 16-18-2-14).**
 17 ~~(1)~~ **(2)** A hospital (as defined in IC 16-18-2-179).
 18 ~~(2)~~ **(3)** A hospital based health facility (as defined in
 19 IC 16-18-2-180).
 20 ~~(3)~~ **(4)** A medical center (as defined in IC 16-18-2-223.4).
 21 The term does not include a professional corporation (as defined in
 22 IC 23-1.5-1-10) comprised of health care professionals (as defined in
 23 IC 23-1.5-1-8) formed to render professional services as set forth in
 24 IC 23-1.5-2-3(a)(4) or a health care professional (as defined in
 25 IC 23-1.5-1-8) who bills for a service or product provided under
 26 IC 22-3-2 through IC 22-3-6 as an individual or a member of a group
 27 practice or another medical service provider that uses the CMS 1500
 28 form for Medicare reimbursement.
 29 (k) "Pecuniary liability" means the responsibility of an employer or
 30 the employer's insurance carrier for the payment of the charges for each
 31 specific service or product for human medical treatment provided
 32 under IC 22-3-2 through IC 22-3-6, as follows:
 33 (1) This subdivision applies before July 1, 2014, to all medical
 34 service providers, and after June 30, 2014, to a medical service
 35 provider that is not a medical service facility. Payment of the
 36 charges in a defined community, equal to or less than the charges
 37 made by medical service providers at the eightieth percentile in
 38 the same community for like services or products.
 39 (2) This subdivision applies after June 30, 2014, to a medical
 40 service facility. Payment of the charges in a reasonable amount,
 41 which is established by payment of one (1) of the following:
 42 (A) The amount negotiated at any time between the medical



1 service facility and any of the following, if an amount has been
 2 negotiated:
 3 (i) The employer.
 4 (ii) The employer's insurance carrier.
 5 (iii) A billing review service on behalf of a person described
 6 in item (i) or (ii).
 7 (iv) A direct provider network that has contracted with a
 8 person described in item (i) or (ii).
 9 (B) Two hundred percent (200%) of the amount that would be
 10 paid to the medical service facility on the same date for the
 11 same service or product under the medical service facility's
 12 Medicare reimbursement rate, if an amount has not been
 13 negotiated as described in clause (A).

14 (l) "Service or product" or "services and products" refers to medical,
 15 hospital, surgical, or nursing service, treatment, and supplies provided
 16 under IC 22-3-2 through IC 22-3-6.

17 SECTION 3. IC 22-3-7-9, AS AMENDED BY P.L.99-2014,
 18 SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 19 JULY 1, 2015]: Sec. 9. (a) As used in this chapter, "employer" includes
 20 the state and any political subdivision, any municipal corporation
 21 within the state, any individual or the legal representative of a deceased
 22 individual, firm, association, limited liability company, or corporation
 23 or the receiver or trustee of the same, using the services of another for
 24 pay. A parent corporation and its subsidiaries shall each be considered
 25 joint employers of the corporation's, the parent's, or the subsidiaries'
 26 employees for purposes of sections 6 and 33 of this chapter. Both a
 27 lessor and a lessee of employees shall each be considered joint
 28 employers of the employees provided by the lessor to the lessee for
 29 purposes of sections 6 and 33 of this chapter. The term also includes an
 30 employer that provides on-the-job training under the federal School to
 31 Work Opportunities Act (20 U.S.C. 6101 et seq.) to the extent set forth
 32 under section 2.5 of this chapter. If the employer is insured, the term
 33 includes the employer's insurer so far as applicable. However, the
 34 inclusion of an employer's insurer within this definition does not allow
 35 an employer's insurer to avoid payment for services rendered to an
 36 employee with the approval of the employer. The term does not include
 37 a nonprofit corporation that is recognized as tax exempt under Section
 38 501(c)(3) of the Internal Revenue Code (as defined in IC 6-3-1-11(a))
 39 to the extent the corporation enters into an independent contractor
 40 agreement with a person for the performance of youth coaching
 41 services on a part-time basis.

42 (b) As used in this chapter, "employee" means every person,



1 including a minor, in the service of another, under any contract of hire
 2 or apprenticeship written or implied, except one whose employment is
 3 both casual and not in the usual course of the trade, business,
 4 occupation, or profession of the employer. For purposes of this chapter
 5 the following apply:

6 (1) Any reference to an employee who has suffered disablement,
 7 when the employee is dead, also includes the employee's legal
 8 representative, dependents, and other persons to whom
 9 compensation may be payable.

10 (2) An owner of a sole proprietorship may elect to include the
 11 owner as an employee under this chapter if the owner is actually
 12 engaged in the proprietorship business. If the owner makes this
 13 election, the owner must serve upon the owner's insurance carrier
 14 and upon the board written notice of the election. No owner of a
 15 sole proprietorship may be considered an employee under this
 16 chapter unless the notice has been received. If the owner of a sole
 17 proprietorship:

18 (A) is an independent contractor in the construction trades and
 19 does not make the election provided under this subdivision,
 20 the owner must obtain a certificate of exemption under section
 21 34.5 of this chapter; or

22 (B) is an independent contractor and does not make the
 23 election provided under this subdivision, the owner may obtain
 24 a certificate of exemption under section 34.5 of this chapter.

25 (3) A partner in a partnership may elect to include the partner as
 26 an employee under this chapter if the partner is actually engaged
 27 in the partnership business. If a partner makes this election, the
 28 partner must serve upon the partner's insurance carrier and upon
 29 the board written notice of the election. No partner may be
 30 considered an employee under this chapter until the notice has
 31 been received. If a partner in a partnership:

32 (A) is an independent contractor in the construction trades and
 33 does not make the election provided under this subdivision,
 34 the partner must obtain a certificate of exemption under
 35 section 34.5 of this chapter; or

36 (B) is an independent contractor and does not make the
 37 election provided under this subdivision, the partner may
 38 obtain a certificate of exemption under section 34.5 of this
 39 chapter.

40 (4) Real estate professionals are not employees under this chapter
 41 if:

42 (A) they are licensed real estate agents;



- 1 (B) substantially all their remuneration is directly related to
2 sales volume and not the number of hours worked; and
3 (C) they have written agreements with real estate brokers
4 stating that they are not to be treated as employees for tax
5 purposes.
- 6 (5) A person is an independent contractor in the construction
7 trades and not an employee under this chapter if the person is an
8 independent contractor under the guidelines of the United States
9 Internal Revenue Service.
- 10 (6) An owner-operator that provides a motor vehicle and the
11 services of a driver under a written contract that is subject to
12 IC 8-2.1-24-23, 45 IAC 16-1-13, or 49 CFR 376, to a motor
13 carrier is not an employee of the motor carrier for purposes of this
14 chapter. The owner-operator may elect to be covered and have the
15 owner-operator's drivers covered under a worker's compensation
16 insurance policy or authorized self-insurance that insures the
17 motor carrier if the owner-operator pays the premiums as
18 requested by the motor carrier. An election by an owner-operator
19 under this subdivision does not terminate the independent
20 contractor status of the owner-operator for any purpose other than
21 the purpose of this subdivision.
- 22 (7) An unpaid participant under the federal School to Work
23 Opportunities Act (20 U.S.C. 6101 et seq.) is an employee to the
24 extent set forth under section 2.5 of this chapter.
- 25 (8) A person who enters into an independent contractor agreement
26 with a nonprofit corporation that is recognized as tax exempt
27 under Section 501(c)(3) of the Internal Revenue Code (as defined
28 in IC 6-3-1-11(a)) to perform youth coaching services on a
29 part-time basis is not an employee for purposes of this chapter.
- 30 (9) An officer of a corporation who is an employee of the
31 corporation under this chapter may elect not to be an employee of
32 the corporation under this chapter. If an officer makes this
33 election, the officer must serve written notice of the election on
34 the corporation's insurance carrier and the board. An officer of a
35 corporation may not be considered to be excluded as an employee
36 under this chapter until the notice is received by the insurance
37 carrier and the board.
- 38 (10) An individual who is not an employee of the state or a
39 political subdivision is considered to be a temporary employee of
40 the state for purposes of this chapter while serving as a member
41 of a mobile support unit on duty for training, an exercise, or a
42 response, as set forth in IC 10-14-3-19(c)(2)(B).



1 (c) As used in this chapter, "minor" means an individual who has
2 not reached seventeen (17) years of age. A minor employee shall be
3 considered as being of full age for all purposes of this chapter.
4 However, if the employee is a minor who, at the time of the last
5 exposure, is employed, required, suffered, or permitted to work in
6 violation of the child labor laws of this state, the amount of
7 compensation and death benefits, as provided in this chapter, shall be
8 double the amount which would otherwise be recoverable. The
9 insurance carrier shall be liable on its policy for one-half (1/2) of the
10 compensation or benefits that may be payable on account of the
11 disability or death of the minor, and the employer shall be wholly liable
12 for the other one-half (1/2) of the compensation or benefits. If the
13 employee is a minor who is not less than sixteen (16) years of age and
14 who has not reached seventeen (17) years of age, and who at the time
15 of the last exposure is employed, suffered, or permitted to work at any
16 occupation which is not prohibited by law, the provisions of this
17 subsection prescribing double the amount otherwise recoverable do not
18 apply. The rights and remedies granted to a minor under this chapter on
19 account of disease shall exclude all rights and remedies of the minor,
20 the minor's parents, the minor's personal representatives, dependents,
21 or next of kin at common law, statutory or otherwise, on account of any
22 disease.

23 (d) This chapter does not apply to casual laborers as defined in
24 subsection (b), nor to farm or agricultural employees, nor to household
25 employees, nor to railroad employees engaged in train service as
26 engineers, firemen, conductors, brakemen, flagmen, baggagemen, or
27 foremen in charge of yard engines and helpers assigned thereto, nor to
28 their employers with respect to these employees. Also, this chapter
29 does not apply to employees or their employers with respect to
30 employments in which the laws of the United States provide for
31 compensation or liability for injury to the health, disability, or death by
32 reason of diseases suffered by these employees.

33 (e) As used in this chapter, "disablement" means the event of
34 becoming disabled from earning full wages at the work in which the
35 employee was engaged when last exposed to the hazards of the
36 occupational disease by the employer from whom the employee claims
37 compensation or equal wages in other suitable employment, and
38 "disability" means the state of being so incapacitated.

39 (f) For the purposes of this chapter, no compensation shall be
40 payable for or on account of any occupational diseases unless
41 disablement, as defined in subsection (e), occurs within two (2) years
42 after the last day of the last exposure to the hazards of the disease



- 1 except for the following:
- 2 (1) In all cases of occupational diseases caused by the inhalation
- 3 of silica dust or coal dust, no compensation shall be payable
- 4 unless disablement, as defined in subsection (e), occurs within
- 5 three (3) years after the last day of the last exposure to the hazards
- 6 of the disease.
- 7 (2) In all cases of occupational disease caused by the exposure to
- 8 radiation, no compensation shall be payable unless disablement,
- 9 as defined in subsection (e), occurs within two (2) years from the
- 10 date on which the employee had knowledge of the nature of the
- 11 employee's occupational disease or, by exercise of reasonable
- 12 diligence, should have known of the existence of such disease and
- 13 its causal relationship to the employee's employment.
- 14 (3) In all cases of occupational diseases caused by the inhalation
- 15 of asbestos dust, no compensation shall be payable unless
- 16 disablement, as defined in subsection (e), occurs within three (3)
- 17 years after the last day of the last exposure to the hazards of the
- 18 disease if the last day of the last exposure was before July 1, 1985.
- 19 (4) In all cases of occupational disease caused by the inhalation
- 20 of asbestos dust in which the last date of the last exposure occurs
- 21 on or after July 1, 1985, and before July 1, 1988, no compensation
- 22 shall be payable unless disablement, as defined in subsection (e),
- 23 occurs within twenty (20) years after the last day of the last
- 24 exposure.
- 25 (5) In all cases of occupational disease caused by the inhalation
- 26 of asbestos dust in which the last date of the last exposure occurs
- 27 on or after July 1, 1988, no compensation shall be payable unless
- 28 disablement (as defined in subsection (e)) occurs within
- 29 thirty-five (35) years after the last day of the last exposure.
- 30 (g) For the purposes of this chapter, no compensation shall be
- 31 payable for or on account of death resulting from any occupational
- 32 disease unless death occurs within two (2) years after the date of
- 33 disablement. However, this subsection does not bar compensation for
- 34 death:
- 35 (1) where death occurs during the pendency of a claim filed by an
- 36 employee within two (2) years after the date of disablement and
- 37 which claim has not resulted in a decision or has resulted in a
- 38 decision which is in process of review or appeal; or
- 39 (2) where, by agreement filed or decision rendered, a
- 40 compensable period of disability has been fixed and death occurs
- 41 within two (2) years after the end of such fixed period, but in no
- 42 event later than three hundred (300) weeks after the date of



- 1 disablement.
- 2 (h) As used in this chapter, "billing review service" refers to a
- 3 person or an entity that reviews a medical service provider's bills or
- 4 statements for the purpose of determining pecuniary liability. The term
- 5 includes an employer's worker's compensation insurance carrier if the
- 6 insurance carrier performs such a review.
- 7 (i) As used in this chapter, "billing review standard" means the data
- 8 used by a billing review service to determine pecuniary liability.
- 9 (j) As used in this chapter, "community" means a geographic service
- 10 area based on ZIP code districts defined by the United States Postal
- 11 Service according to the following groupings:
- 12 (1) The geographic service area served by ZIP codes with the first
- 13 three (3) digits 463 and 464.
- 14 (2) The geographic service area served by ZIP codes with the first
- 15 three (3) digits 465 and 466.
- 16 (3) The geographic service area served by ZIP codes with the first
- 17 three (3) digits 467 and 468.
- 18 (4) The geographic service area served by ZIP codes with the first
- 19 three (3) digits 469 and 479.
- 20 (5) The geographic service area served by ZIP codes with the first
- 21 three (3) digits 460, 461 (except 46107), and 473.
- 22 (6) The geographic service area served by the 46107 ZIP code and
- 23 ZIP codes with the first three (3) digits 462.
- 24 (7) The geographic service area served by ZIP codes with the first
- 25 three (3) digits 470, 471, 472, 474, and 478.
- 26 (8) The geographic service area served by ZIP codes with the first
- 27 three (3) digits 475, 476, and 477.
- 28 (k) As used in this chapter, "medical service provider" refers to a
- 29 person or an entity that provides services or products to an employee
- 30 under this chapter. Except as otherwise provided in this chapter, the
- 31 term includes a medical service facility.
- 32 (l) As used in this chapter, "medical service facility" means any of
- 33 the following that provides a service or product under this chapter and
- 34 uses **or would be required to use** the CMS 1450 (UB-04) form for
- 35 Medicare reimbursement:
- 36 **(1) An ambulatory outpatient surgical center (as defined in**
- 37 **IC 16-18-2-14).**
- 38 ~~(+)~~ **(2)** A hospital (as defined in IC 16-18-2-179).
- 39 ~~(-)~~ **(3)** A hospital based health facility (as defined in
- 40 IC 16-18-2-180).
- 41 ~~(=)~~ **(4)** A medical center (as defined in IC 16-18-2-223.4).
- 42 The term does not include a professional corporation (as defined in



1 IC 23-1.5-1-10) comprised of health care professionals (as defined in
 2 IC 23-1.5-1-8) formed to render professional services as set forth in
 3 IC 23-1.5-2-3(a)(4) or a health care professional (as defined in
 4 IC 23-1.5-1-8) who bills for a service or product provided under this
 5 chapter as an individual or a member of a group practice or another
 6 medical service provider that uses the CMS 1500 form for Medicare
 7 reimbursement.

8 (m) As used in this chapter, "pecuniary liability" means the
 9 responsibility of an employer or the employer's insurance carrier for the
 10 payment of the charges for each specific service or product for human
 11 medical treatment provided under this chapter as follows:

12 (1) This subdivision applies before July 1, 2014, to all medical
 13 service providers, and after June 30, 2014, to a medical service
 14 provider that is not a medical service facility. Payment of the
 15 charges in a defined community, equal to or less than the charges
 16 made by medical service providers at the eightieth percentile in
 17 the same community for like services or products.

18 (2) This subdivision applies after June 30, 2014, to a medical
 19 service facility. Payment of the charges in a reasonable amount,
 20 which is established by payment of one (1) of the following:

21 (A) The amount negotiated at any time between the medical
 22 service facility and any of the following, if an amount has been
 23 negotiated:

24 (i) The employer.

25 (ii) The employer's insurance carrier.

26 (iii) A billing review service on behalf of a person described
 27 in item (i) or (ii).

28 (iv) A direct provider network that has contracted with a
 29 person described in item (i) or (ii).

30 (B) Two hundred percent (200%) of the amount that would be
 31 paid to the medical service facility on the same date for the
 32 same service or product under the medical service facility's
 33 Medicare reimbursement rate, if an amount has not been
 34 negotiated as described in clause (A).

35 (n) "Service or product" or "services and products" refers to
 36 medical, hospital, surgical, or nursing service, treatment, and supplies
 37 provided under this chapter.

38 SECTION 4. IC 22-3-7-17.2, AS AMENDED BY P.L.99-2014,
 39 SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 40 JULY 1, 2015]: Sec. 17.2. (a) A billing review service shall adhere to
 41 the following requirements to determine the pecuniary liability of an
 42 employer or an employer's insurance carrier for a specific service or



1 product covered under this chapter provided before July 1, 2014, by all
 2 medical service providers, and after June 30, 2014, by a medical
 3 service provider that is not a medical service facility:

4 (1) The formation of a billing review standard, and any
 5 subsequent analysis or revision of the standard, must use data that
 6 is based on the medical service provider billing charges as
 7 submitted to the employer and the employer's insurance carrier
 8 from the same community. This subdivision does not apply when
 9 a unique or specialized service or product does not have sufficient
 10 comparative data to allow for a reasonable comparison.

11 (2) Data used to determine pecuniary liability must be compiled
 12 on or before June 30 and December 31 of each year.

13 (3) Billing review standards must be revised for prospective
 14 future payments of medical service provider bills to provide for
 15 payment of the charges at a rate not more than the charges made
 16 by eighty percent (80%) of the medical service providers during
 17 the prior six (6) months within the same community. The data
 18 used to perform the analysis and revision of the billing review
 19 standards may not be more than two (2) years old and must be
 20 periodically updated by a representative inflationary or
 21 deflationary factor. Reimbursement for these charges may not
 22 exceed the actual charge invoiced by the medical service
 23 provider.

24 (b) This subsection applies after June 30, 2014, to a medical service
 25 facility. The pecuniary liability of an employer or an employer's
 26 insurance carrier for a specific service or product covered under this
 27 chapter and provided by a medical service facility is equal to a
 28 reasonable amount, which is established by payment of one (1) of the
 29 following:

30 (1) The amount negotiated at any time between the medical
 31 service facility and any of the following:

32 (A) The employer.

33 (B) The employer's insurance carrier.

34 (C) A billing review service on behalf of a person described in
 35 clause (A) or (B).

36 (D) A direct provider network that has contracted with a
 37 person described in clause (A) or (B).

38 (2) Two hundred percent (200%) of the amount that would be
 39 paid to the medical service facility on the same date for the same
 40 service or product under the medical service facility's Medicare
 41 reimbursement rate, if an amount has not been negotiated as
 42 described in subdivision (1).



1 **(c) This subsection applies to a medical service facility that is:**

2 **(1) an ambulatory outpatient surgical center (as defined in**
3 **IC 16-18-2-14); and**

4 **(2) not reimbursed for an implant under subsection (b).**

5 **Payment for an implant furnished to an employee under this**
6 **chapter is equal to one hundred twenty-five percent (125%) of the**
7 **implant's cost as evidenced by the invoice amount.**

8 ~~(c)~~ **(d)** A medical service provider may request an explanation from
9 a billing review service if the medical service provider's bill has been
10 reduced as a result of application of the eightieth percentile or of a
11 Current Procedural Terminology (CPT) or Medicare coding change.
12 The request must be made not later than sixty (60) days after receipt of
13 the notice of the reduction. If a request is made, the billing review
14 service must provide:

15 (1) the name of the billing review service used to make the
16 reduction;

17 (2) the dollar amount of the reduction;

18 (3) the dollar amount of the medical service at the eightieth
19 percentile; and

20 (4) in the case of a CPT or Medicare coding change, the basis
21 upon which the change was made;

22 not later than thirty (30) days after the date of the request.

23 ~~(d)~~ **(e)** If, after a hearing, the worker's compensation board finds that
24 a billing review service used a billing review standard that did not
25 comply with subsection (a)(1) through (a)(3), as applicable, in
26 determining the pecuniary liability of an employer or an employer's
27 insurance carrier for a medical service provider's charge for services or
28 products covered under occupational disease compensation, the
29 worker's compensation board may assess a civil penalty against the
30 billing review service in an amount not less than one hundred dollars
31 (\$100) and not more than one thousand dollars (\$1,000).



COMMITTEE REPORT

Madam President: The Senate Committee on Pensions and Labor, to which was referred Senate Bill No. 33, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 22-3-3-5.2, AS AMENDED BY P.L.99-2014, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: Sec. 5.2. (a) A billing review service shall adhere to the following requirements to determine the pecuniary liability of an employer or an employer's insurance carrier for a specific service or product covered under worker's compensation provided before July 1, 2014, by all medical service providers, and after June 30, 2014, by a medical service provider that is not a medical service facility:

- (1) The formation of a billing review standard, and any subsequent analysis or revision of the standard, must use data that is based on the medical service provider billing charges as submitted to the employer and the employer's insurance carrier from the same community. This subdivision does not apply when a unique or specialized service or product does not have sufficient comparative data to allow for a reasonable comparison.
- (2) Data used to determine pecuniary liability must be compiled on or before June 30 and December 31 of each year.
- (3) Billing review standards must be revised for prospective future payments of medical service provider bills to provide for payment of the charges at a rate not more than the charges made by eighty percent (80%) of the medical service providers during the prior six (6) months within the same community. The data used to perform the analysis and revision of the billing review standards may not be more than two (2) years old and must be periodically updated by a representative inflationary or deflationary factor. Reimbursement for these charges may not exceed the actual charge invoiced by the medical service provider.

(b) This subsection applies after June 30, 2014, to a medical service facility. The pecuniary liability of an employer or an employer's insurance carrier for a specific service or product covered under worker's compensation and provided by a medical service facility is equal to a reasonable amount, which is established by payment of one (1) of the following:

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(1) The amount negotiated at any time between the medical service facility and any of the following:

(A) The employer.

(B) The employer's insurance carrier.

(C) A billing review service on behalf of a person described in clause (A) or (B).

(D) A direct provider network that has contracted with a person described in clause (A) or (B).

(2) Two hundred percent (200%) of the amount that would be paid to the medical service facility on the same date for the same service or product under the medical service facility's Medicare reimbursement rate, if an amount has not been negotiated as described in subdivision (1).

(c) This subsection applies to a medical service facility that is:

(1) an ambulatory outpatient surgical center (as defined in IC 16-18-2-14); and

(2) not reimbursed for an implant under subsection (b).

Payment for an implant furnished to an employee under IC 22-3-2 through IC 22-3-6 is equal to one hundred twenty-five percent (125%) of the implant's cost as evidenced by the invoice amount.

~~(c)~~ **(d)** A medical service provider may request an explanation from a billing review service if the medical service provider's bill has been reduced as a result of application of the eightieth percentile or of a Current Procedural Terminology (CPT) or Medicare coding change. The request must be made not later than sixty (60) days after receipt of the notice of the reduction. If a request is made, the billing review service must provide:

(1) the name of the billing review service used to make the reduction;

(2) the dollar amount of the reduction;

(3) the dollar amount of the service or product at the eightieth percentile; and

(4) in the case of a CPT or Medicare coding change, the basis upon which the change was made;

not later than thirty (30) days after the date of the request.

~~(d)~~ **(e)** If, after a hearing, the worker's compensation board finds that a billing review service used a billing review standard that did not comply with subsection (a)(1) through (a)(3), as applicable, in determining the pecuniary liability of an employer or an employer's insurance carrier for a medical service provider's charge for services or products covered under worker's compensation, the worker's compensation board may assess a civil penalty against the billing



review service in an amount not less than one hundred dollars (\$100) and not more than one thousand dollars (\$1,000)."

Page 7, line 19, after "uses" insert "**or would be required to use**".

Page 13, line 39, after "uses" insert "**or would be required to use**".

Page 14, after line 41, begin a new paragraph and insert:

"SECTION 4. IC 22-3-7-17.2, AS AMENDED BY P.L.99-2014, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: Sec. 17.2. (a) A billing review service shall adhere to the following requirements to determine the pecuniary liability of an employer or an employer's insurance carrier for a specific service or product covered under this chapter provided before July 1, 2014, by all medical service providers, and after June 30, 2014, by a medical service provider that is not a medical service facility:

(1) The formation of a billing review standard, and any subsequent analysis or revision of the standard, must use data that is based on the medical service provider billing charges as submitted to the employer and the employer's insurance carrier from the same community. This subdivision does not apply when a unique or specialized service or product does not have sufficient comparative data to allow for a reasonable comparison.

(2) Data used to determine pecuniary liability must be compiled on or before June 30 and December 31 of each year.

(3) Billing review standards must be revised for prospective future payments of medical service provider bills to provide for payment of the charges at a rate not more than the charges made by eighty percent (80%) of the medical service providers during the prior six (6) months within the same community. The data used to perform the analysis and revision of the billing review standards may not be more than two (2) years old and must be periodically updated by a representative inflationary or deflationary factor. Reimbursement for these charges may not exceed the actual charge invoiced by the medical service provider.

(b) This subsection applies after June 30, 2014, to a medical service facility. The pecuniary liability of an employer or an employer's insurance carrier for a specific service or product covered under this chapter and provided by a medical service facility is equal to a reasonable amount, which is established by payment of one (1) of the following:

(1) The amount negotiated at any time between the medical service facility and any of the following:

(A) The employer.



(B) The employer's insurance carrier.

(C) A billing review service on behalf of a person described in clause (A) or (B).

(D) A direct provider network that has contracted with a person described in clause (A) or (B).

(2) Two hundred percent (200%) of the amount that would be paid to the medical service facility on the same date for the same service or product under the medical service facility's Medicare reimbursement rate, if an amount has not been negotiated as described in subdivision (1).

(c) This subsection applies to a medical service facility that is:

(1) an ambulatory outpatient surgical center (as defined in IC 16-18-2-14); and

(2) not reimbursed for an implant under subsection (b).

Payment for an implant furnished to an employee under this chapter is equal to one hundred twenty-five percent (125%) of the implant's cost as evidenced by the invoice amount.

~~(c)~~ **(d)** A medical service provider may request an explanation from a billing review service if the medical service provider's bill has been reduced as a result of application of the eightieth percentile or of a Current Procedural Terminology (CPT) or Medicare coding change. The request must be made not later than sixty (60) days after receipt of the notice of the reduction. If a request is made, the billing review service must provide:

(1) the name of the billing review service used to make the reduction;

(2) the dollar amount of the reduction;

(3) the dollar amount of the medical service at the eightieth percentile; and

(4) in the case of a CPT or Medicare coding change, the basis upon which the change was made;

not later than thirty (30) days after the date of the request.

~~(d)~~ **(e)** If, after a hearing, the worker's compensation board finds that a billing review service used a billing review standard that did not comply with subsection (a)(1) through (a)(3), as applicable, in determining the pecuniary liability of an employer or an employer's insurance carrier for a medical service provider's charge for services or products covered under occupational disease compensation, the worker's compensation board may assess a civil penalty against the



billing review service in an amount not less than one hundred dollars (\$100) and not more than one thousand dollars (\$1,000).".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 33 as introduced.)

BOOTS, Chairperson

Committee Vote: Yeas 10, Nays 0.

