



Reprinted  
January 31, 2020

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## HOUSE BILL No. 1332

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DIGEST OF HB 1332 (Updated January 30, 2020 3:23 pm - DI 128)

**Citations Affected:** IC 22-3.

**Synopsis:** Ambulatory outpatient surgical centers. Provides that ambulatory outpatient surgical centers may be reimbursed in an amount not to exceed 225% of the ambulatory outpatient surgical center's Medicare reimbursement rate. Provides that the payment to an ambulatory outpatient surgical center for a medical device under worker's compensation may not exceed the invoice amount plus 3%.

**Effective:** July 1, 2020; January 1, 2021.

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### Lehman, Carbaugh

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January 13, 2020, read first time and referred to Committee on Employment, Labor and Pensions.  
January 28, 2020, amended, reported — Do Pass.  
January 30, 2020, read second time, amended, ordered engrossed.

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HB 1332—LS 6804/DI 128





Reprinted  
January 31, 2020

Second Regular Session of the 121st General Assembly (2020)

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 2019 Regular Session of the General Assembly.

## HOUSE BILL No. 1332

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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, AS AMENDED BY P.L.275-2013,  
2 SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
3 JANUARY 1, 2021]: Sec. 5. (a) The pecuniary liability of the employer  
4 for a service or product herein required shall be limited to the  
5 following:  
6           (1) This subdivision applies before July 1, 2014, to all medical  
7 service providers, and after June 30, 2014, to a medical service  
8 provider that is not a medical service facility **or an ambulatory**  
9 **outpatient surgical center**. Such charges as prevail as provided  
10 under IC 22-3-6-1(k)(1), in the same community (as defined in  
11 IC 22-3-6-1(h)) for a like service or product to injured persons.  
12           (2) This subdivision applies after June 30, 2014, to a medical  
13 service facility **and an ambulatory outpatient surgical center**.  
14           The amount provided under IC 22-3-6-1(k)(2).  
15           (b) The employee and the employee's estate do not have liability to  
16 a health care provider for payment for services obtained under  
17 IC 22-3-3-4.

HB 1332—LS 6804/DI 128



1 (c) The right to order payment for all services or products provided  
2 under IC 22-3-2 through IC 22-3-6 is solely with the board.

3 (d) All claims by a medical service provider for payment for  
4 services or products are against the employer and the employer's  
5 insurance carrier, if any, and must be made with the board under  
6 IC 22-3-2 through IC 22-3-6. After June 30, 2011, a medical service  
7 provider must file an application for adjustment of a claim for a  
8 medical service provider's fee with the board not later than two (2)  
9 years after the receipt of an initial written communication from the  
10 employer, the employer's insurance carrier, if any, or an agent acting on  
11 behalf of the employer after the medical service provider submits a bill  
12 for services or products. To offset a part of the board's expenses related  
13 to the administration of medical service provider reimbursement  
14 disputes, a medical service facility shall pay a filing fee of sixty dollars  
15 (\$60) in a balance billing case. The filing fee must accompany each  
16 application filed with the board. If an employer, an employer's  
17 insurance carrier, or an agent acting on behalf of the employer denies  
18 or fails to pay any amount on a claim submitted by a medical service  
19 facility, a filing fee is not required to accompany an application that is  
20 filed for the denied or unpaid claim. A medical service provider may  
21 combine up to ten (10) individual claims into one (1) application  
22 whenever:

- 23 (1) all individual claims involve the same employer, insurance  
24 carrier, or billing review service; and  
25 (2) the amount of each individual claim does not exceed two  
26 hundred dollars (\$200).

27 (e) The worker's compensation board may withhold the approval of  
28 the fees of the attending physician in a case until the attending  
29 physician files a report with the worker's compensation board on the  
30 form prescribed by the board.

31 SECTION 2. IC 22-3-3-5.2, AS AMENDED BY P.L.99-2014,  
32 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
33 JULY 1, 2020]: Sec. 5.2. (a) A billing review service shall adhere to  
34 the following requirements to determine the pecuniary liability of an  
35 employer or an employer's insurance carrier for a specific service or  
36 product covered under worker's compensation provided before July 1,  
37 2014, by all medical service providers, and after June 30, 2014, by a  
38 medical service provider that is not a medical service facility **or, after  
39 December 31, 2020, an ambulatory outpatient surgical center:**

- 40 (1) The formation of a billing review standard, and any  
41 subsequent analysis or revision of the standard, must use data that  
42 is based on the medical service provider billing charges as



1 submitted to the employer and the employer's insurance carrier  
 2 from the same community. This subdivision does not apply when  
 3 a unique or specialized service or product does not have sufficient  
 4 comparative data to allow for a reasonable comparison.

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

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

18 (b) This subsection applies after June 30, 2014, to a medical service  
 19 facility **or, after December 31, 2020, an ambulatory outpatient**  
 20 **surgical center**. The pecuniary liability of an employer or an  
 21 employer's insurance carrier for a specific service or product covered  
 22 under worker's compensation and provided by a medical service facility  
 23 **or an ambulatory outpatient surgical center** is equal to a reasonable  
 24 amount, which is established by payment of one (1) of the following **as**  
 25 **applicable:**

26 (1) The amount negotiated at any time between the medical  
 27 service facility **or ambulatory outpatient surgical center** and  
 28 any of the following:

29 (A) The employer.

30 (B) The employer's insurance carrier.

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

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

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

40 (3) **For an ambulatory outpatient surgical center, an amount**  
 41 **not to exceed two hundred twenty-five percent (225%) of the**  
 42 **amount that would be paid to the ambulatory outpatient**



1           **surgical center on the same date for the same service or**  
 2           **product under the ambulatory outpatient surgical center's**  
 3           **Medicare reimbursement rate, if an amount has not been**  
 4           **negotiated as described in subdivision (1). However, the**  
 5           **payment to an ambulatory outpatient surgical center for an**  
 6           **implant furnished to an employee under IC 22-3-2 through**  
 7           **IC 22-3-6 may not exceed the invoice amount plus three**  
 8           **percent (3%).**

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

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

18           (2) the dollar amount of the reduction;

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

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

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

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

33          SECTION 3. IC 22-3-6-1, AS AMENDED BY P.L.63-2019,  
 34          SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 35          JANUARY 1, 2021]: Sec. 1. In IC 22-3-2 through IC 22-3-6, unless the  
 36          context otherwise requires:

37           (a) "Employer" includes the state and any political subdivision, any  
 38           municipal corporation within the state, any individual or the legal  
 39           representative of a deceased individual, firm, association, limited  
 40           liability company, limited liability partnership, or corporation or the  
 41           receiver or trustee of the same, using the services of another for pay. A  
 42           corporation, limited liability company, or limited liability partnership



1 that controls the activities of another corporation, limited liability  
2 company, or limited liability partnership, or a corporation and a limited  
3 liability company or a corporation and a limited liability partnership  
4 that are commonly owned entities, or the controlled corporation,  
5 limited liability company, limited liability partnership, or commonly  
6 owned entities, and a parent corporation and its subsidiaries shall each  
7 be considered joint employers of the corporation's, the controlled  
8 corporation's, the limited liability company's, the limited liability  
9 partnership's, the commonly owned entities', the parent's, or the  
10 subsidiaries' employees for purposes of IC 22-3-2-6 and IC 22-3-3-31.  
11 Both a lessor and a lessee of employees shall each be considered joint  
12 employers of the employees provided by the lessor to the lessee for  
13 purposes of IC 22-3-2-6 and IC 22-3-3-31. If the employer is insured,  
14 the term includes the employer's insurer so far as applicable. However,  
15 the inclusion of an employer's insurer within this definition does not  
16 allow an employer's insurer to avoid payment for services rendered to  
17 an employee with the approval of the employer. The term also includes  
18 an employer that provides on-the-job training under the federal School  
19 to Work Opportunities Act (20 U.S.C. 6101 et seq.) to the extent set  
20 forth in IC 22-3-2-2.5. The term does not include a nonprofit  
21 corporation that is recognized as tax exempt under Section 501(c)(3)  
22 of the Internal Revenue Code (as defined in IC 6-3-1-11(a)) to the  
23 extent the corporation enters into an independent contractor agreement  
24 with a person for the performance of youth coaching services on a  
25 part-time basis.

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

31 (1) An executive officer elected or appointed and empowered in  
32 accordance with the charter and bylaws of a corporation, other  
33 than a municipal corporation or governmental subdivision or a  
34 charitable, religious, educational, or other nonprofit corporation,  
35 is an employee of the corporation under IC 22-3-2 through  
36 IC 22-3-6. An officer of a corporation who is an employee of the  
37 corporation under IC 22-3-2 through IC 22-3-6 may elect not to  
38 be an employee of the corporation under IC 22-3-2 through  
39 IC 22-3-6. An officer of a corporation who is also an owner of any  
40 interest in the corporation may elect not to be an employee of the  
41 corporation under IC 22-3-2 through IC 22-3-6. If an officer  
42 makes this election, the officer must serve written notice of the



1 election on the corporation's insurance carrier and the board. An  
2 officer of a corporation may not be considered to be excluded as  
3 an employee under IC 22-3-2 through IC 22-3-6 until the notice  
4 is received by the insurance carrier and the board.

5 (2) An executive officer of a municipal corporation or other  
6 governmental subdivision or of a charitable, religious,  
7 educational, or other nonprofit corporation may, notwithstanding  
8 any other provision of IC 22-3-2 through IC 22-3-6, be brought  
9 within the coverage of its insurance contract by the corporation by  
10 specifically including the executive officer in the contract of  
11 insurance. The election to bring the executive officer within the  
12 coverage shall continue for the period the contract of insurance is  
13 in effect, and during this period, the executive officers thus  
14 brought within the coverage of the insurance contract are  
15 employees of the corporation under IC 22-3-2 through IC 22-3-6.

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

20 (4) An owner of a sole proprietorship may elect to include the  
21 owner as an employee under IC 22-3-2 through IC 22-3-6 if the  
22 owner is actually engaged in the proprietorship business. If the  
23 owner makes this election, the owner must serve upon the owner's  
24 insurance carrier and upon the board written notice of the  
25 election. No owner of a sole proprietorship may be considered an  
26 employee under IC 22-3-2 through IC 22-3-6 until the notice has  
27 been received. If the owner of a sole proprietorship:

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

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

35 (5) A partner in a partnership may elect to include the partner as  
36 an employee under IC 22-3-2 through IC 22-3-6 if the partner is  
37 actually engaged in the partnership business. If a partner makes  
38 this election, the partner must serve upon the partner's insurance  
39 carrier and upon the board written notice of the election. No  
40 partner may be considered an employee under IC 22-3-2 through  
41 IC 22-3-6 until the notice has been received. If a partner in a  
42 partnership:





- 1 (A) is an independent contractor in the construction trades and  
2 does not make the election provided under this subdivision,  
3 the partner must obtain a certificate of exemption under  
4 IC 22-3-2-14.5; or  
5 (B) is an independent contractor and does not make the  
6 election provided under this subdivision, the partner may  
7 obtain a certificate of exemption under IC 22-3-2-14.5.
- 8 (6) Real estate professionals are not employees under IC 22-3-2  
9 through IC 22-3-6 if:  
10 (A) they are licensed real estate agents;  
11 (B) substantially all their remuneration is directly related to  
12 sales volume and not the number of hours worked; and  
13 (C) they have written agreements with real estate brokers  
14 stating that they are not to be treated as employees for tax  
15 purposes.
- 16 (7) A person is an independent contractor and not an employee  
17 under IC 22-3-2 through IC 22-3-6 if the person is an independent  
18 contractor under the guidelines of the United States Internal  
19 Revenue Service.
- 20 (8) An owner-operator that provides a motor vehicle and the  
21 services of a driver under a written contract that is subject to  
22 IC 8-2.1-24-23, 45 IAC 16-1-13, or 49 CFR 376 to a motor carrier  
23 is not an employee of the motor carrier for purposes of IC 22-3-2  
24 through IC 22-3-6. The owner-operator may elect to be covered  
25 and have the owner-operator's drivers covered under a worker's  
26 compensation insurance policy or authorized self-insurance that  
27 insures the motor carrier if the owner-operator pays the premiums  
28 as requested by the motor carrier. An election by an  
29 owner-operator under this subdivision does not terminate the  
30 independent contractor status of the owner-operator for any  
31 purpose other than the purpose of this subdivision.
- 32 (9) A member or manager in a limited liability company may elect  
33 to include the member or manager as an employee under  
34 IC 22-3-2 through IC 22-3-6 if the member or manager is actually  
35 engaged in the limited liability company business. If a member or  
36 manager makes this election, the member or manager must serve  
37 upon the member's or manager's insurance carrier and upon the  
38 board written notice of the election. A member or manager may  
39 not be considered an employee under IC 22-3-2 through IC 22-3-6  
40 until the notice has been received.
- 41 (10) An unpaid participant under the federal School to Work  
42 Opportunities Act (20 U.S.C. 6101 et seq.) is an employee to the



1 extent set forth in IC 22-3-2-2.5.

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

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

13 (13) A driver providing drive away operations is an independent  
14 contractor and not an employee when:

15 (A) the vehicle being driven is the commodity being delivered;  
16 and

17 (B) the driver has entered into an agreement with the party  
18 arranging for the transportation that specifies the driver is an  
19 independent contractor and not an employee.

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

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

25 (2) If the employee is a minor who, at the time of the accident, is  
26 employed, required, suffered, or permitted to work in violation of  
27 IC 20-33-3-35, the amount of compensation and death benefits,  
28 as provided in IC 22-3-2 through IC 22-3-6, shall be double the  
29 amount which would otherwise be recoverable. The insurance  
30 carrier shall be liable on its policy for one-half (1/2) of the  
31 compensation or benefits that may be payable on account of the  
32 injury or death of the minor, and the employer shall be liable for  
33 the other one-half (1/2) of the compensation or benefits. If the  
34 employee is a minor who is not less than sixteen (16) years of age  
35 and who has not reached seventeen (17) years of age and who at  
36 the time of the accident is employed, suffered, or permitted to  
37 work at any occupation which is not prohibited by law, this  
38 subdivision does not apply.

39 (3) A minor employee who, at the time of the accident, is a  
40 student performing services for an employer as part of an  
41 approved program under IC 20-37-2-7 shall be considered a  
42 full-time employee for the purpose of computing compensation



1 for permanent impairment under IC 22-3-3-10. The average  
 2 weekly wages for such a student shall be calculated as provided  
 3 in subsection (d)(4).

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

12 (d) "Average weekly wages" means the earnings of the injured  
 13 employee in the employment in which the employee was working at the  
 14 time of the injury during the period of fifty-two (52) weeks  
 15 immediately preceding the date of injury, divided by fifty-two (52),  
 16 except as follows:

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

22 (2) Where the employment prior to the injury extended over a  
 23 period of less than fifty-two (52) weeks, the method of dividing  
 24 the earnings during that period by the number of weeks and parts  
 25 thereof during which the employee earned wages shall be  
 26 followed, if results just and fair to both parties will be obtained.  
 27 Where by reason of the shortness of the time during which the  
 28 employee has been in the employment of the employee's employer  
 29 or of the casual nature or terms of the employment it is  
 30 impracticable to compute the average weekly wages, as defined  
 31 in this subsection, regard shall be had to the average weekly  
 32 amount which during the fifty-two (52) weeks previous to the  
 33 injury was being earned by a person in the same grade employed  
 34 at the same work by the same employer or, if there is no person so  
 35 employed, by a person in the same grade employed in the same  
 36 class of employment in the same district.

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

40 (4) In computing the average weekly wages to be used in  
 41 calculating an award for permanent impairment under  
 42 IC 22-3-3-10 for a student employee in an approved training



- 1 program under IC 20-37-2-7, the following formula shall be used.  
 2 Calculate the product of:  
 3 (A) the student employee's hourly wage rate; multiplied by  
 4 (B) forty (40) hours.  
 5 The result obtained is the amount of the average weekly wages for  
 6 the student employee.
- 7 (e) "Injury" and "personal injury" mean only injury by accident  
 8 arising out of and in the course of the employment and do not include  
 9 a disease in any form except as it results from the injury.
- 10 (f) "Billing review service" refers to a person or an entity that  
 11 reviews a medical service provider's bills or statements for the purpose  
 12 of determining pecuniary liability. The term includes an employer's  
 13 worker's compensation insurance carrier if the insurance carrier  
 14 performs such a review.
- 15 (g) "Billing review standard" means the data used by a billing  
 16 review service to determine pecuniary liability.
- 17 (h) "Community" means a geographic service area based on ZIP  
 18 code districts defined by the United States Postal Service according to  
 19 the following groupings:
- 20 (1) The geographic service area served by ZIP codes with the first  
 21 three (3) digits 463 and 464.
  - 22 (2) The geographic service area served by ZIP codes with the first  
 23 three (3) digits 465 and 466.
  - 24 (3) The geographic service area served by ZIP codes with the first  
 25 three (3) digits 467 and 468.
  - 26 (4) The geographic service area served by ZIP codes with the first  
 27 three (3) digits 469 and 479.
  - 28 (5) The geographic service area served by ZIP codes with the first  
 29 three (3) digits 460, 461 (except 46107), and 473.
  - 30 (6) The geographic service area served by the 46107 ZIP code and  
 31 ZIP codes with the first three (3) digits 462.
  - 32 (7) The geographic service area served by ZIP codes with the first  
 33 three (3) digits 470, 471, 472, 474, and 478.
  - 34 (8) The geographic service area served by ZIP codes with the first  
 35 three (3) digits 475, 476, and 477.
- 36 (i) "Medical service provider" refers to a person or an entity that  
 37 provides services or products to an employee under IC 22-3-2 through  
 38 IC 22-3-6. Except as otherwise provided in IC 22-3-2 through  
 39 IC 22-3-6, the term includes a medical service facility.
- 40 (j) "Medical service facility" means any of the following that  
 41 provides a service or product under IC 22-3-2 through IC 22-3-6 and  
 42 uses the CMS 1450 (UB-04) form for Medicare reimbursement:



- 1 (1) A hospital (as defined in IC 16-18-2-179).
- 2 (2) A hospital based health facility (as defined in  
3 IC 16-18-2-180).
- 4 (3) A medical center (as defined in IC 16-18-2-223.4).
- 5 The term does not include a professional corporation (as defined in  
6 IC 23-1.5-1-10) comprised of health care professionals (as defined in  
7 IC 23-1.5-1-8) formed to render professional services as set forth in  
8 IC 23-1.5-2-3(a)(4) or a health care professional (as defined in  
9 IC 23-1.5-1-8) who bills for a service or product provided under  
10 IC 22-3-2 through IC 22-3-6 as an individual or a member of a group  
11 practice or another medical service provider that uses the CMS 1500  
12 form for Medicare reimbursement.
- 13 (k) "Pecuniary liability" means the responsibility of an employer or  
14 the employer's insurance carrier for the payment of the charges for each  
15 specific service or product for human medical treatment provided  
16 under IC 22-3-2 through IC 22-3-6, as follows:
- 17 (1) This subdivision applies before July 1, 2014, to all medical  
18 service providers, and after June 30, 2014, to a medical service  
19 provider that is not a medical service facility **or an ambulatory**  
20 **outpatient surgical center (as defined in IC 16-18-2-14).**  
21 Payment of the charges in a defined community, equal to or less  
22 than the charges made by medical service providers at the  
23 eightieth percentile in the same community for like services or  
24 products.
- 25 (2) Payment of the charges in a reasonable amount, which is  
26 established by payment of one (1) of the following, **as applicable:**
- 27 (A) The amount negotiated at any time between the medical  
28 service facility **or ambulatory outpatient surgical center** and  
29 any of the following, if an amount has been negotiated:
- 30 (i) The employer.
- 31 (ii) The employer's insurance carrier.
- 32 (iii) A billing review service on behalf of a person described  
33 in item (i) or (ii).
- 34 (iv) A direct provider network that has contracted with a  
35 person described in item (i) or (ii).
- 36 (B) **For a medical service facility,** two hundred percent  
37 (200%) of the amount that would be paid to the medical  
38 service facility on the same date for the same service or  
39 product under the medical service facility's Medicare  
40 reimbursement rate, if an amount has not been negotiated as  
41 described in clause (A).
- 42 (C) **For an ambulatory outpatient surgical center, an**



1           **amount not to exceed two hundred twenty-five percent**  
 2           **(225%) of the amount that would be paid to the**  
 3           **ambulatory outpatient surgical center on the same date for**  
 4           **the same service or product under the ambulatory**  
 5           **outpatient surgical center's Medicare reimbursement rate,**  
 6           **if an amount has not been negotiated as described in clause**  
 7           **(A). However, the payment to an ambulatory outpatient**  
 8           **surgical center for an implant furnished to an employee**  
 9           **under IC 22-3-2 through IC 22-3-6 may not exceed the**  
 10           **invoice amount plus three percent (3%).**

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

14           SECTION 4. IC 22-3-7-9, AS AMENDED BY P.L.204-2018,  
 15           SECTION 11, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 16           JANUARY 1, 2021]: Sec. 9. (a) As used in this chapter, "employer"  
 17           includes the state and any political subdivision, any municipal  
 18           corporation within the state, any individual or the legal representative  
 19           of a deceased individual, firm, association, limited liability company,  
 20           limited liability partnership, or corporation or the receiver or trustee of  
 21           the same, using the services of another for pay. A corporation, limited  
 22           liability company, or limited liability partnership that controls the  
 23           activities of another corporation, limited liability company, or limited  
 24           liability partnership, or a corporation and a limited liability company  
 25           or a corporation and a limited liability partnership that are commonly  
 26           owned entities, or the controlled corporation, limited liability company,  
 27           limited liability partnership, or commonly owned entities, and a parent  
 28           corporation and its subsidiaries shall each be considered joint  
 29           employers of the corporation's, the controlled corporation's, the limited  
 30           liability company's, the limited liability partnership's, the commonly  
 31           owned entities', the parent's, or the subsidiaries' employees for purposes  
 32           of sections 6 and 33 of this chapter. 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 sections 6 and 33  
 35           of this chapter. The term also includes an employer that provides  
 36           on-the-job training under the federal School to Work Opportunities Act  
 37           (20 U.S.C. 6101 et seq.) to the extent set forth under section 2.5 of this  
 38           chapter. If the employer is insured, the term includes the employer's  
 39           insurer so far as applicable. However, the inclusion of an employer's  
 40           insurer within this definition does not allow an employer's insurer to  
 41           avoid payment for services rendered to an employee with the approval  
 42           of the employer. 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) As used in this chapter, "employee" means every person,  
 7 including a minor, in the service of another, under any contract of hire  
 8 or apprenticeship written or implied, except one whose employment is  
 9 both casual and not in the usual course of the trade, business,  
 10 occupation, or profession of the employer. For purposes of this chapter  
 11 the following apply:

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

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

24 (A) is an independent contractor in the construction trades and  
 25 does not make the election provided under this subdivision,  
 26 the owner must obtain a certificate of exemption under section  
 27 34.5 of this chapter; or

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

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

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

42 (B) is an independent contractor and does not make the



- 1 election provided under this subdivision, the partner may  
2 obtain a certificate of exemption under section 34.5 of this  
3 chapter.
- 4 (4) Real estate professionals are not employees under this chapter  
5 if:
- 6 (A) they are licensed real estate agents;
  - 7 (B) substantially all their remuneration is directly related to  
8 sales volume and not the number of hours worked; and
  - 9 (C) they have written agreements with real estate brokers  
10 stating that they are not to be treated as employees for tax  
11 purposes.
- 12 (5) A person is an independent contractor in the construction  
13 trades and not an employee under this chapter if the person is an  
14 independent contractor under the guidelines of the United States  
15 Internal Revenue Service.
- 16 (6) An owner-operator that provides a motor vehicle and the  
17 services of a driver under a written contract that is subject to  
18 IC 8-2.1-24-23, 45 IAC 16-1-13, or 49 CFR 376, to a motor  
19 carrier is not an employee of the motor carrier for purposes of this  
20 chapter. The owner-operator may elect to be covered and have the  
21 owner-operator's drivers covered under a worker's compensation  
22 insurance policy or authorized self-insurance that insures the  
23 motor carrier if the owner-operator pays the premiums as  
24 requested by the motor carrier. An election by an owner-operator  
25 under this subdivision does not terminate the independent  
26 contractor status of the owner-operator for any purpose other than  
27 the purpose of this subdivision.
- 28 (7) An unpaid participant under the federal School to Work  
29 Opportunities Act (20 U.S.C. 6101 et seq.) is an employee to the  
30 extent set forth under section 2.5 of this chapter.
- 31 (8) A person who enters into an independent contractor agreement  
32 with a nonprofit corporation that is recognized as tax exempt  
33 under Section 501(c)(3) of the Internal Revenue Code (as defined  
34 in IC 6-3-1-11(a)) to perform youth coaching services on a  
35 part-time basis is not an employee for purposes of this chapter.
- 36 (9) An officer of a corporation who is an employee of the  
37 corporation under this chapter may elect not to be an employee of  
38 the corporation under this chapter. An officer of a corporation  
39 who is also an owner of any interest in the corporation may elect  
40 not to be an employee of the corporation under this chapter. If an  
41 officer makes this election, the officer must serve written notice  
42 of the election on the corporation's insurance carrier and the





1 board. An officer of a corporation may not be considered to be  
2 excluded as an employee under this chapter until the notice is  
3 received by the insurance carrier and the board.

4 (10) An individual who is not an employee of the state or a  
5 political subdivision is considered to be a temporary employee of  
6 the state for purposes of this chapter while serving as a member  
7 of a mobile support unit on duty for training, an exercise, or a  
8 response, as set forth in IC 10-14-3-19(c)(2)(B).

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

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

41 (e) As used in this chapter, "disablement" means the event of  
42 becoming disabled from earning full wages at the work in which the



1 employee was engaged when last exposed to the hazards of the  
2 occupational disease by the employer from whom the employee claims  
3 compensation or equal wages in other suitable employment, and  
4 "disability" means the state of being so incapacitated.

5 (f) For the purposes of this chapter, no compensation shall be  
6 payable for or on account of any occupational diseases unless  
7 disablement, as defined in subsection (e), occurs within two (2) years  
8 after the last day of the last exposure to the hazards of the disease  
9 except for the following:

10 (1) In all cases of occupational diseases caused by the inhalation  
11 of silica dust or coal dust, no compensation shall be payable  
12 unless disablement, as defined in subsection (e), occurs within  
13 three (3) years after the last day of the last exposure to the hazards  
14 of the disease.

15 (2) In all cases of occupational disease caused by the exposure to  
16 radiation, no compensation shall be payable unless disablement,  
17 as defined in subsection (e), occurs within two (2) years from the  
18 date on which the employee had knowledge of the nature of the  
19 employee's occupational disease or, by exercise of reasonable  
20 diligence, should have known of the existence of such disease and  
21 its causal relationship to the employee's employment.

22 (3) In all cases of occupational diseases caused by the inhalation  
23 of asbestos dust, no compensation shall be payable unless  
24 disablement, as defined in subsection (e), occurs within three (3)  
25 years after the last day of the last exposure to the hazards of the  
26 disease if the last day of the last exposure was before July 1, 1985.

27 (4) In all cases of occupational disease caused by the inhalation  
28 of asbestos dust in which the last date of the last exposure occurs  
29 on or after July 1, 1985, and before July 1, 1988, no compensation  
30 shall be payable unless disablement, as defined in subsection (e),  
31 occurs within twenty (20) years after the last day of the last  
32 exposure.

33 (5) In all cases of occupational disease caused by the inhalation  
34 of asbestos dust in which the last date of the last exposure occurs  
35 on or after July 1, 1988, no compensation shall be payable unless  
36 disablement (as defined in subsection (e)) occurs within  
37 thirty-five (35) years after the last day of the last exposure.

38 (g) For the purposes of this chapter, no compensation shall be  
39 payable for or on account of death resulting from any occupational  
40 disease unless death occurs within two (2) years after the date of  
41 disablement. However, this subsection does not bar compensation for  
42 death:



- 1 (1) where death occurs during the pendency of a claim filed by an  
 2 employee within two (2) years after the date of disablement and  
 3 which claim has not resulted in a decision or has resulted in a  
 4 decision which is in process of review or appeal; or  
 5 (2) where, by agreement filed or decision rendered, a  
 6 compensable period of disability has been fixed and death occurs  
 7 within two (2) years after the end of such fixed period, but in no  
 8 event later than three hundred (300) weeks after the date of  
 9 disablement.

10 (h) As used in this chapter, "billing review service" refers to a  
 11 person or an entity that reviews a medical service provider's bills or  
 12 statements for the purpose of determining pecuniary liability. The term  
 13 includes an employer's worker's compensation insurance carrier if the  
 14 insurance carrier performs such a review.

15 (i) As used in this chapter, "billing review standard" means the data  
 16 used by a billing review service to determine pecuniary liability.

17 (j) As used in this chapter, "community" means a geographic service  
 18 area based on ZIP code districts defined by the United States Postal  
 19 Service according to the following groupings:

- 20 (1) The geographic service area served by ZIP codes with the first  
 21 three (3) digits 463 and 464.  
 22 (2) The geographic service area served by ZIP codes with the first  
 23 three (3) digits 465 and 466.  
 24 (3) The geographic service area served by ZIP codes with the first  
 25 three (3) digits 467 and 468.  
 26 (4) The geographic service area served by ZIP codes with the first  
 27 three (3) digits 469 and 479.  
 28 (5) The geographic service area served by ZIP codes with the first  
 29 three (3) digits 460, 461 (except 46107), and 473.  
 30 (6) The geographic service area served by the 46107 ZIP code and  
 31 ZIP codes with the first three (3) digits 462.  
 32 (7) The geographic service area served by ZIP codes with the first  
 33 three (3) digits 470, 471, 472, 474, and 478.  
 34 (8) The geographic service area served by ZIP codes with the first  
 35 three (3) digits 475, 476, and 477.

36 (k) As used in this chapter, "medical service provider" refers to a  
 37 person or an entity that provides services or products to an employee  
 38 under this chapter. Except as otherwise provided in this chapter, the  
 39 term includes a medical service facility.

40 (l) As used in this chapter, "medical service facility" means any of  
 41 the following that provides a service or product under this chapter and  
 42 uses the CMS 1450 (UB-04) form for Medicare reimbursement:



1 (1) A hospital (as defined in IC 16-18-2-179).

2 (2) A hospital based health facility (as defined in  
3 IC 16-18-2-180).

4 (3) A medical center (as defined in IC 16-18-2-223.4).

5 The term does not include a professional corporation (as defined in  
6 IC 23-1.5-1-10) comprised of health care professionals (as defined in  
7 IC 23-1.5-1-8) formed to render professional services as set forth in  
8 IC 23-1.5-2-3(a)(4) or a health care professional (as defined in  
9 IC 23-1.5-1-8) who bills for a service or product provided under this  
10 chapter as an individual or a member of a group practice or another  
11 medical service provider that uses the CMS 1500 form for Medicare  
12 reimbursement.

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

17 (1) This subdivision applies before July 1, 2014, to all medical  
18 service providers, and after June 30, 2014, to a medical service  
19 provider that is not a medical service facility **or ambulatory**  
20 **outpatient surgical center (as defined in IC 16-18-2-14)**.  
21 Payment of the charges in a defined community, equal to or less  
22 than the charges made by medical service providers at the  
23 eightieth percentile in the same community for like services or  
24 products.

25 (2) Payment of the charges in a reasonable amount, which is  
26 established by payment of one (1) of the following, **as applicable**:

27 (A) The amount negotiated at any time between the medical  
28 service facility **or ambulatory outpatient surgical center** and  
29 any of the following, if an amount has been negotiated:

30 (i) The employer.

31 (ii) The employer's insurance carrier.

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

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

36 (B) **For a medical service facility**, two hundred percent  
37 (200%) of the amount that would be paid to the medical  
38 service facility on the same date for the same service or  
39 product under the medical service facility's Medicare  
40 reimbursement rate, if an amount has not been negotiated as  
41 described in clause (A).

42 (C) **For an ambulatory outpatient surgical center, an**



1           **amount not to exceed two hundred twenty-five percent**  
 2           **(225%) of the amount that would be paid to the**  
 3           **ambulatory outpatient surgical center on the same date for**  
 4           **the same service or product under the ambulatory**  
 5           **outpatient surgical center's Medicare reimbursement rate,**  
 6           **if an amount has not been negotiated as described in clause**  
 7           **(A). The payment to an ambulatory outpatient surgical**  
 8           **center for an implant furnished to an employee under**  
 9           **IC 22-3-2 through IC 22-3-6 may not exceed the invoice**  
 10           **amount plus three percent (3%).**

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

14           SECTION 5. IC 22-3-7-17.2, AS AMENDED BY P.L.99-2014,  
 15           SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 16           JULY 1, 2020]: Sec. 17.2. (a) A billing review service shall adhere to  
 17           the following requirements to determine the pecuniary liability of an  
 18           employer or an employer's insurance carrier for a specific service or  
 19           product covered under this chapter provided before July 1, 2014, by all  
 20           medical service providers, and after June 30, 2014, by a medical  
 21           service provider that is not a medical service facility **or, after**  
 22           **December 31, 2020, an ambulatory outpatient surgical center:**

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

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

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



1 (b) This subsection applies after June 30, 2014, to a medical service  
 2 facility **or, after December 31, 2020, an ambulatory outpatient**  
 3 **surgical center**. The pecuniary liability of an employer or an  
 4 employer's insurance carrier for a specific service or product covered  
 5 under this chapter and provided by a medical service facility **or an**  
 6 **ambulatory outpatient surgical center** is equal to a reasonable  
 7 amount, which is established by payment of one (1) of the following **as**  
 8 **applicable:**

9 (1) The amount negotiated at any time between the medical  
 10 service facility **or ambulatory outpatient surgical center** and  
 11 any of the following:

12 (A) The employer.

13 (B) The employer's insurance carrier.

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

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

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

23 (3) **For an ambulatory outpatient surgical center, an amount**  
 24 **not to exceed two hundred twenty-five percent (225%) of the**  
 25 **amount that would be paid to the ambulatory outpatient**  
 26 **surgical center on the same date for the same service or**  
 27 **product under the ambulatory outpatient surgical center's**  
 28 **Medicare reimbursement rate, if an amount has not been**  
 29 **negotiated as described in subdivision (1). However, the**  
 30 **payment to an ambulatory outpatient surgical center for an**  
 31 **implant furnished to an employee under IC 22-3-2 through**  
 32 **IC 22-3-6 may not exceed the invoice amount plus three**  
 33 **percent (3%).**

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

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



1           (2) the dollar amount of the reduction;  
2           (3) the dollar amount of the medical service at the eightieth  
3           percentile; and  
4           (4) in the case of a CPT or Medicare coding change, the basis  
5           upon which the change was made;  
6           not later than thirty (30) days after the date of the request.  
7           (d) If, after a hearing, the worker's compensation board finds that a  
8           billing review service used a billing review standard that did not  
9           comply with subsection (a)(1) through (a)(3), as applicable, in  
10          determining the pecuniary liability of an employer or an employer's  
11          insurance carrier for a medical service provider's charge for services or  
12          products covered under occupational disease compensation, the  
13          worker's compensation board may assess a civil penalty against the  
14          billing review service in an amount not less than one hundred dollars  
15          (\$100) and not more than one thousand dollars (\$1,000).



## COMMITTEE REPORT

Mr. Speaker: Your Committee on Employment, Labor and Pensions, to which was referred House Bill 1332, has had the same under consideration and begs leave to report the same back to the House 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, AS AMENDED BY P.L.275-2013, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2021]: Sec. 5. (a) The pecuniary liability of the employer for a service or product herein required shall be limited to the following:

(1) This subdivision applies before July 1, 2014, to all medical service providers, and after June 30, 2014, to a medical service provider that is not a medical service facility **or an ambulatory outpatient surgical center**. Such charges as prevail as provided under IC 22-3-6-1(k)(1), in the same community (as defined in IC 22-3-6-1(h)) for a like service or product to injured persons.

(2) This subdivision applies after June 30, 2014, to a medical service facility **and an ambulatory outpatient surgical center**.

The amount provided under IC 22-3-6-1(k)(2).

(b) The employee and the employee's estate do not have liability to a health care provider for payment for services obtained under IC 22-3-3-4.

(c) The right to order payment for all services or products provided under IC 22-3-2 through IC 22-3-6 is solely with the board.

(d) All claims by a medical service provider for payment for services or products are against the employer and the employer's insurance carrier, if any, and must be made with the board under IC 22-3-2 through IC 22-3-6. After June 30, 2011, a medical service provider must file an application for adjustment of a claim for a medical service provider's fee with the board not later than two (2) years after the receipt of an initial written communication from the employer, the employer's insurance carrier, if any, or an agent acting on behalf of the employer after the medical service provider submits a bill for services or products. To offset a part of the board's expenses related to the administration of medical service provider reimbursement disputes, a medical service facility shall pay a filing fee of sixty dollars (\$60) in a balance billing case. The filing fee must accompany each application filed with the board. If an employer, an employer's insurance carrier, or an agent acting on behalf of the employer denies





or fails to pay any amount on a claim submitted by a medical service facility, a filing fee is not required to accompany an application that is filed for the denied or unpaid claim. A medical service provider may combine up to ten (10) individual claims into one (1) application whenever:

- (1) all individual claims involve the same employer, insurance carrier, or billing review service; and
- (2) the amount of each individual claim does not exceed two hundred dollars (\$200).

(e) The worker's compensation board may withhold the approval of the fees of the attending physician in a case until the attending physician files a report with the worker's compensation board on the form prescribed by the board.

SECTION 2. IC 22-3-3-5.2, AS AMENDED BY P.L.99-2014, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: 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 **or, after December 31, 2020, an ambulatory outpatient surgical center:**

- (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 **or, after December 31, 2020, an ambulatory outpatient surgical center**. 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 **or an ambulatory outpatient surgical center** is equal to a reasonable amount, which is established by payment of one (1) of the following **as applicable**:

(1) The amount negotiated at any time between the medical service facility **or ambulatory outpatient surgical center** 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) **For a medical service facility, an amount not to exceed 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).**

(3) **For an ambulatory outpatient surgical center, an amount not to exceed two hundred twenty-five percent (225%) of the amount that would be paid to the ambulatory outpatient surgical center on the same date for the same service or product under the ambulatory outpatient surgical center's Medicare reimbursement rate, if an amount has not been negotiated as described in subdivision (1). However, the payment to an ambulatory outpatient surgical center for an implant furnished to an employee under IC 22-3-2 through IC 22-3-6 may not exceed the invoice amount plus three percent (3%).**

(c) 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) 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 1, line 3, delete "JULY 1, 2020]" and insert "JANUARY 1, 2021]:".

Page 7, delete lines 36 through 37.

Page 7, line 38, reset in roman "(1)".

Page 7, line 38, delete "(2)".

Page 7, line 39, reset in roman "(2)".

Page 7, line 39, delete "(3)".

Page 7, line 41, reset in roman "(3)".

Page 7, line 41, delete "(4)".

Page 8, line 14, delete "facility." and insert "**facility or an ambulatory outpatient surgical center (as defined in IC 16-18-2-14).**".

Page 8, line 19, delete "following:" and insert "**following, as applicable:**".

Page 8, line 21, after "facility" insert "**or ambulatory outpatient surgical center**".

Page 8, line 29, delete "Two" and insert "**For a medical service facility, an amount not to exceed two**".

Page 8, between lines 33 and 34, begin a new line double block indented and insert:

**"(C) For an ambulatory outpatient surgical center, an amount not to exceed two hundred twenty-five percent (225%) of the amount that would be paid to the ambulatory outpatient surgical center on the same date for the same service or product under the ambulatory outpatient surgical center's Medicare reimbursement rate,**



**if an amount has not been negotiated as described in clause (A). However, the payment to an ambulatory outpatient surgical center for an implant furnished to an employee under IC 22-3-2 through IC 22-3-6 may not exceed the invoice amount plus three percent (3%)."**

Page 8, line 39, delete "JULY 1, 2020]" and insert "JANUARY 1, 2021]:".

Page 14, delete lines 24 through 25.

Page 14, line 26, reset in roman "(1)".

Page 14, line 26, delete "(2)".

Page 14, line 27, reset in roman "(2)".

Page 14, line 27, delete "(3)".

Page 14, line 29, reset in roman "(3)".

Page 14, line 29, delete "(4)".

Page 15, line 2, delete "facility." and insert "**facility or ambulatory outpatient surgical center (as defined in IC 16-18-2-14).**".

Page 15, line 7, delete "following:" and insert "**following, as applicable:**".

Page 15, line 9, after "facility" insert "**or ambulatory outpatient surgical center**".

Page 15, line 17, delete "Two" and insert "**For a medical service facility, an amount not to exceed two**".

Page 15, between lines 21 and 22, begin a new line double block indented and insert:

**"(C) For an ambulatory outpatient surgical center, an amount not to exceed two hundred twenty-five percent (225%) of the amount that would be paid to the ambulatory outpatient surgical center on the same date for the same service or product under the ambulatory outpatient surgical center's Medicare reimbursement rate, if an amount has not been negotiated as described in clause (A). The payment to an ambulatory outpatient surgical center for an implant furnished to an employee under IC 22-3-2 through IC 22-3-6 may not exceed the invoice amount plus three percent (3%)."**

Page 15, after line 24, 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, 2020]: 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 **or, after December 31, 2020, an ambulatory outpatient surgical center:**

(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 **or, after December 31, 2020, an ambulatory outpatient surgical center.** 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 **or an ambulatory outpatient surgical center** is equal to a reasonable amount, which is established by payment of one (1) of the following **as applicable:**

(1) The amount negotiated at any time between the medical service facility **or ambulatory outpatient surgical center** 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) **For a medical service facility, an amount not to exceed 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).

**(3) For an ambulatory outpatient surgical center, an amount not to exceed two hundred twenty-five percent (225%) of the amount that would be paid to the ambulatory outpatient surgical center on the same date for the same service or product under the ambulatory outpatient surgical center's Medicare reimbursement rate, if an amount has not been negotiated as described in subdivision (1). However, the payment to an ambulatory outpatient surgical center for an implant furnished to an employee under IC 22-3-2 through IC 22-3-6 may not exceed the invoice amount plus three percent (3%).**

(c) 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) 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 HB 1332 as introduced.)

VANNATTER

Committee Vote: yeas 10, nays 0.

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HOUSE MOTION

Mr. Speaker: I move that House Bill 1332 be amended to read as follows:

Page 3, line 35, delete "an amount not to exceed".

Page 11, line 37, delete "an amount not to exceed".

Page 18, line 37, delete "an amount not to exceed".

Page 20, line 19, delete "an amount not to exceed".

(Reference is to HB 1332 as printed January 28, 2020.)

BARRETT

