LEGISLATIVE BILL 588

Approved by the Governor May 24, 2007

Introduced by Business and Labor Committee: Cornett, 45, Chairperson; Lathrop, 12; McGill, 26; Rogert, 16; Wallman, 30; White, 8

FOR AN ACT relating to workers' compensation; to amend section 48-121, Reissue Revised Statutes of Nebraska, and sections 48-120 and 48-1,110, Revised Statutes Cumulative Supplement, 2006; to change provisions relating to the hospital fee schedule, payment of providers, and disability compensation; to provide powers and duties for the Nebraska Workers' Compensation Court; to define terms; to harmonize provisions; to provide operative dates; and to repeal the original sections.

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

Section 1. Section 48-120, Revised Statutes Cumulative Supplement, 2006, is amended to read:

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

(b) Except as provided in section 2 of this act, the ~~The~~ compensation court ~~may~~ shall establish schedules of ~~maximum~~ fees for such services. ~~If the compensation court establishes such a schedule, it shall publish and furnish such schedule to the public.~~ The compensation court shall review such ~~schedule~~ schedules at least biennially and adopt appropriate changes when necessary. The compensation court may contract with any person, firm, corporation, organization, or government agency to secure adequate data to establish such fees. ~~The provider or supplier of such services shall not collect or attempt to collect from any employer, insurer, government, or injured employee or dependent or the estate of any injured or deceased employee any amount in excess of the maximum fee established by the compensation court for any such service.~~ The compensation court shall publish and furnish to the public the fee schedules established pursuant to this subdivision and section 2 of this act. The compensation court ~~shall~~ may establish and charge a fee to recover the cost of published fee schedules. ~~Notwithstanding any other provision of this section, the compensation court may exclude from the application of such schedules those services performed under a managed care plan certified pursuant to section 48-120.02.~~

(c) Reimbursement for inpatient hospital services provided by hospitals located in or within fifteen miles of a Nebraska city of the metropolitan class or primary class and by other hospitals with fifty-one or more licensed beds shall be according to the Diagnostic Related Group inpatient hospital fee schedule established in section 2 of this act.

(d) A workers' compensation insurer, risk management pool, self-insured employer, or managed care plan certified pursuant to section 48-120.02 may contract with a provider or provider network for medical, surgical, or hospital services. Such contract may establish fees for services different than the fee schedules established under subdivision (1)(b) of this section or established under section 2 of this act. Such contract shall be in writing and mutually agreed upon prior to the date services are provided.

(e) The provider or supplier of such services shall not collect or attempt to collect from any employer, insurer, government, or injured employee or dependent or the estate of any injured or deceased employee any amount in excess of (i) the fee established by the compensation court for any such service, (ii) the fee established under section 2 of this act, or (iii) the fee contracted under subdivision (1)(d) of this section.

(2)(a) The employee has the right to select a physician who has maintained the employee's medical records prior to an injury and has a documented history of treatment with the employee prior to an injury or a physician who has maintained the medical records of an immediate family

member of the employee prior to an injury and has a documented history of treatment with an immediate family member of the employee prior to an injury. For purposes of this subsection, immediate family member means the employee's spouse, children, parents, stepchildren, and stepparents. The employer shall notify the employee following an injury of such right of selection in a form and manner and within a timeframe established by the compensation court. If the employer fails to notify the employee of such right of selection or fails to notify the employee of such right of selection in a form and manner and within a timeframe established by the compensation court, then the employee has the right to select a physician. If the employee fails to exercise such right of selection in a form and manner and within a timeframe established by the compensation court following notice by the employer pursuant to this subsection, then the employer has the right to select the physician. If selection of the initial physician is made by the employee or employer pursuant to this subsection following notice by the employer pursuant to this subsection, the employee or employer shall not change the initial selection of physician made pursuant to this subsection unless such change is agreed to by the employee and employer or is ordered by the compensation court pursuant to subsection (6) of this section. If compensability is denied by the workers' compensation insurer, risk management pool, or self-insured employer, (i) the employee has the right to select a physician and shall not be made to enter a managed care plan and (ii) the employer is liable for medical, surgical, and hospital services subsequently found to be compensable. If the employer has exercised the right to select a physician pursuant to this subsection and if the compensation court subsequently orders reasonable medical services previously refused to be furnished to the employee by the physician selected by the employer, the compensation court shall allow the employee to select another physician to furnish further medical services. If the employee selects a physician located in a community not the home or place of work of the employee and a physician is available in the local community or in a closer community, no travel expenses shall be required to be paid by the employer or his or her workers' compensation insurer.

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

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

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

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

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

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

(4) All physicians and other providers of medical services attending injured employees shall comply with all the rules and regulations adopted and promulgated by the compensation court and shall make such reports as may be required by it at any time and at such times as required by it upon the condition or treatment of any injured employee or upon any other matters concerning cases in which they are employed. All medical and hospital information relevant to the particular injury shall, on demand, be made available to the employer, the employee, the workers' compensation insurer, and the compensation court. The party requesting such medical and hospital information shall pay the cost thereof. No such relevant information developed in connection with treatment or examination for which compensation is sought

shall be considered a privileged communication for purposes of a workers' compensation claim. When a physician or other provider of medical services willfully fails to make any report required of him or her under this section, the compensation court may order the forfeiture of his or her right to all or part of payment due for services rendered in connection with the particular case.

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

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

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

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

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

Sec. 2. (1) This section applies only to hospitals identified in subdivision (1)(c) of section 48-120.

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

(3) For purposes of this section:

(a) Current Medicare Factor is derived from the Diagnostic Related Group Prospective Payment System as established by the Centers for Medicare

and Medicaid Services under the United States Department of Health and Human Services and means the summation of the following components:

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

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

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

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

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

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

(d) Workers' Compensation Factor means the Current Medicare Factor for each hospital multiplied by one hundred fifty percent.

(4) The Diagnostic Related Group inpatient hospital fee schedule shall include at least thirty-eight of the most frequently utilized Medicare Diagnostic Related Groups for workers' compensation with the goal that the fee schedule covers at least ninety percent of all workers' compensation inpatient hospital claims submitted by hospitals identified in subdivision (1)(c) of section 48-120. Rehabilitation Diagnostic Related Groups shall not be included in the Diagnostic Related Group inpatient hospital fee schedule. Claims for inpatient trauma services shall not be reimbursed under the Diagnostic Related Group inpatient hospital fee schedule established under this section until January 1, 2010. Claims for inpatient trauma services prior to January 1, 2010, shall be reimbursed under the fees established by the compensation court pursuant to subdivision (1)(b) of section 48-120 or as contracted pursuant to subdivision (1)(d) of such section. For purposes of this subsection, trauma means a major single-system or multisystem injury requiring immediate medical or surgical intervention or treatment to prevent death or permanent disability.

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

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

(b) The Stop-Loss Threshold amount shall be the Diagnostic Related Group reimbursement amount calculated in subdivision (5)(a) of this section multiplied by two and one-half;

(c) For charges over the Stop-Loss Threshold amount of the schedule, the hospital shall be reimbursed the Diagnostic Related Group reimbursement amount calculated in subdivision (5)(a) of this section plus sixty percent of the charges over the Stop-Loss Threshold amount; and

(d) For charges less than the Stop-Loss Threshold amount of the schedule, the hospital shall be reimbursed the lower of the hospital's billed charges or the Diagnostic Related Group reimbursement amount calculated in subdivision (5)(a) of this section.

(6) For charges for all other stays or services that are not on the Diagnostic Related Group inpatient hospital fee schedule or are not contracted for under subdivision (1)(d) of section 48-120, the hospital shall be reimbursed under the schedule of fees established by the compensation court pursuant to subdivision (1)(b) of section 48-120.

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

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

(9) Each hospital, workers' compensation insurer, risk management pool, and self-insured employer shall report to the administrator of the compensation court by October 15 of each year, in the form and manner prescribed by the administrator, the total number of claims submitted for each

Diagnostic Related Group and the number of times billed charges exceeded the Stop-Loss Threshold amount for each Diagnostic Related Group.

(10) The compensation court may add or subtract Diagnostic Related Groups in striving to achieve the goal of including those Diagnostic Related Groups that encompass at least ninety percent of the inpatient hospital workers' compensation claims submitted by hospitals identified in subdivision (1)(c) of section 48-120. The administrator of the compensation court shall annually make necessary adjustments to comply with the Current Medicare Weights and shall annually adjust the Current Medicare Factor for each hospital based on the annual statement submitted pursuant to subsection (8) of this section.

Sec. 3. (1) Regarding payment of a claim for medical, surgical, or hospital services for a state employee under the Nebraska Workers' Compensation Act, the Prompt Payment Act applies.

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

(a) The workers' compensation insurer, risk management pool, or self-insured employer shall notify the provider within fifteen business days after receiving a claim as to what information is necessary to process the claim. Failure to notify the provider assumes the workers' compensation insurer, risk management pool, or self-insured employer has all information necessary to pay the claim. The workers' compensation insurer, risk management pool, or self-insured employer shall pay providers in accordance with section 48-120 and section 2 of this act within thirty business days after receipt of all information necessary to process the claim. Failure to pay the provider within the thirty days will cause the workers' compensation insurer, risk management pool, or self-insured employer to reimburse the provider's billed charges instead of the scheduled or contracted fees;

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

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

Sec. 4. Section 48-121, Reissue Revised Statutes of Nebraska, is amended to read:

48-121 The following schedule of compensation is hereby established for injuries resulting in disability:

(1) For total disability, the compensation during such disability shall be sixty-six and two-thirds percent of the wages received at the time of injury, but such compensation shall not be more than the maximum weekly income benefit specified in section 48-121.01 nor less than the minimum weekly income benefit specified in section 48-121.01, except that if at the time of injury the employee receives wages of less than the minimum weekly income benefit specified in section 48-121.01, then he or she shall receive the full amount of such wages per week as compensation. Nothing in this subdivision shall require payment of compensation after disability shall cease; ~~.~~

(2) For disability partial in character, except the particular cases mentioned in subdivision (3) of this section, the compensation shall be sixty-six and two-thirds percent of the difference between the wages received at the time of the injury and the earning power of the employee thereafter, but such compensation shall not be more than the maximum weekly income benefit specified in section 48-121.01. This compensation shall be paid during the period of such partial disability but not beyond three hundred weeks. Should total disability be followed by partial disability, the period of three hundred weeks mentioned in this subdivision shall be reduced by the number of weeks during which compensation was paid for such total disability; ~~.~~

(3) For disability resulting from permanent injury of the classes listed in this subdivision, the compensation shall be in addition to the amount paid for temporary disability, except that the compensation for

temporary disability shall cease as soon as the extent of the permanent disability is ascertainable. For disability resulting from permanent injury of the following classes, compensation shall be: For the loss of a thumb, sixty-six and two-thirds percent of daily wages during sixty weeks. For the loss of a first finger, commonly called the index finger, sixty-six and two-thirds percent of daily wages during thirty-five weeks. For the loss of a second finger, sixty-six and two-thirds percent of daily wages during thirty weeks. For the loss of a third finger, sixty-six and two-thirds percent of daily wages during twenty weeks. For the loss of a fourth finger, commonly called the little finger, sixty-six and two-thirds percent of daily wages during fifteen weeks. The loss of the first phalange of the thumb or of any finger shall be considered to be equal to the loss of one-half of such thumb or finger and compensation shall be for one-half of the periods of time above specified, and the compensation for the loss of one-half of the first phalange shall be for one-fourth of the periods of time above specified. The loss of more than one phalange shall be considered as the loss of the entire finger or thumb, except that in no case shall the amount received for more than one finger exceed the amount provided in this schedule for the loss of a hand. For the loss of a great toe, sixty-six and two-thirds percent of daily wages during thirty weeks. For the loss of one of the toes other than the great toe, sixty-six and two-thirds percent of daily wages during ten weeks. The loss of the first phalange of any toe shall be considered equal to the loss of one-half of such toe, and compensation shall be for one-half of the periods of time above specified. The loss of more than one phalange shall be considered as the loss of the entire toe. For the loss of a hand, sixty-six and two-thirds percent of daily wages during one hundred seventy-five weeks. For the loss of an arm, sixty-six and two-thirds percent of daily wages during two hundred twenty-five weeks. For the loss of a foot, sixty-six and two-thirds percent of daily wages during one hundred fifty weeks. For the loss of a leg, sixty-six and two-thirds percent of daily wages during two hundred fifteen weeks. For the loss of an eye, sixty-six and two-thirds percent of daily wages during one hundred twenty-five weeks. For the loss of an ear, sixty-six and two-thirds percent of daily wages during twenty-five weeks. For the loss of hearing in one ear, sixty-six and two-thirds percent of daily wages during fifty weeks. For the loss of the nose, sixty-six and two-thirds percent of daily wages during fifty weeks.

In any case in which there is a loss or loss of use of more than one member or parts of more than one member set forth in this subdivision, but not amounting to total and permanent disability, compensation benefits shall be paid for the loss or loss of use of each such member or part thereof, with the periods of benefits to run consecutively. The total loss or permanent total loss of use of both hands, or both arms, or both feet, or both legs, or both eyes, or hearing in both ears, or of any two thereof, in one accident, shall constitute total and permanent disability and be compensated for according to subdivision (1) of this section. In all other cases involving a loss or loss of use of both hands, both arms, both feet, both legs, both eyes, or hearing in both ears, or of any two thereof, total and permanent disability shall be determined in accordance with the facts. Amputation between the elbow and the wrist shall be considered as the equivalent of the loss of a hand, and amputation between the knee and the ankle shall be considered as the equivalent of the loss of a foot. Amputation at or above the elbow shall be considered as the loss of an arm, and amputation at or above the knee shall be considered as the loss of a leg. Permanent total loss of the use of a finger, hand, arm, foot, leg, or eye shall be considered as the equivalent of the loss of such finger, hand, arm, foot, leg, or eye. In all cases involving a permanent partial loss of the use or function of any of the members mentioned in this subdivision, the compensation shall bear such relation to the amounts named in such subdivision as the disabilities bear to those produced by the injuries named therein.

If, in the compensation court's discretion, compensation benefits payable for a loss or loss of use of more than one member or parts of more than one member set forth in this subdivision, resulting from the same accident or illness, do not adequately compensate the employee for such loss or loss of use and such loss or loss of use results in at least a thirty percent loss of earning capacity, the compensation court shall, upon request of the employee, determine the employee's loss of earning capacity consistent with the process for such determination under subdivision (1) or (2) of this section, and in such a case the employee shall not be entitled to compensation under this subdivision.

If the employer and the employee are unable to agree upon the amount of compensation to be paid in cases not covered by the schedule, the amount of compensation shall be settled according to sections 48-173 to 48-185.

Compensation under this subdivision shall not be more than the maximum weekly income benefit specified in section 48-121.01 nor less than the minimum weekly income benefit specified in section 48-121.01, except that if at the time of the injury the employee received wages of less than the minimum weekly income benefit specified in section 48-121.01, then he or she shall receive the full amount of such wages per week as compensation; .

(4) For disability resulting from permanent disability, if immediately prior to the accident the rate of wages was fixed by the day or hour, or by the output of the employee, the weekly wages shall be taken to be computed upon the basis of a workweek of a minimum of five days, if the wages are paid by the day, or upon the basis of a workweek of a minimum of forty hours, if the wages are paid by the hour, or upon the basis of a workweek of a minimum of five days or forty hours, whichever results in the higher weekly wage, if the wages are based on the output of the employee; and .

(5) The employee shall be entitled to compensation from his or her employer for temporary disability while undergoing physical or medical rehabilitation and while undergoing vocational rehabilitation whether such vocational rehabilitation is voluntarily offered by the employer and accepted by the employee or is ordered by the Nebraska Workers' Compensation Court or any judge of the compensation court.

Sec. 5. Section 48-1,110, Revised Statutes Cumulative Supplement, 2006, is amended to read:

48-1,110 Sections 48-101 to 48-1,117 and sections 2 and 3 of this act shall be known and may be cited as the Nebraska Workers' Compensation Act.

Sec. 6. Sections 1, 2, 5, 6, and 7 of this act become operative three calendar months after adjournment of this legislative session. Sections 3, 4, and 8 of this act become operative on January 1, 2008.

Sec. 7. Original sections 48-120 and 48-1,110, Revised Statutes Cumulative Supplement, 2006, are repealed.

Sec. 8. Original section 48-121, Reissue Revised Statutes of Nebraska, is repealed.