Worker's Compensation Board of Indiana
Guidelines for Determining the Pecuniary Liability of an Employer to a Medical Service Facility

In order to carry out the intent of the Worker's Compensation Act and effectuate Indiana Code 22-3-3-5.2, the Board hereby adopts the following guidelines for payment for medical services and products provided by medical facilities:

Ambulatory Outpatient Surgical Centers - Effective January 1, 2023, Ambulatory outpatient surgical centers (ASCs), as defined at IC 16-18-2- 14, are considered "Medical service facilities" as that term is defined at IC 22-3-6-1 (J). ASCs shall be reimbursed for care provided to injured workers under IC 22-3-3-5.2 (b); in accordance with Medicare ASC rates at 200% of the allowed amount.

Experimental and Investigational (Excluded) Services - Reasonable and necessary services or products, as defined in IC 22-3-6-1(l), that are excluded under Medicare regulations, as listed in the Medicare National Coverage Determinations Manual, should be reimbursed in accordance with 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, if not covered by a relevant contract or payment agreement.

Medicare Reductions - The 2% sequester reductions applied by CMS shall not be included in bill calculation under IC 22-3-3-5.2.

Outpatient and ASC Procedures - Addendum "E"[1] to Medicare's inpatient prospective payment rules lists certain procedures that are eligible for Medicare reimbursement only when they are performed on an inpatient basis. For purposes of Indiana's workers compensation program, facilities shall be reimbursed for reasonable and necessary procedures conducted there in contradiction of Addendum "E", as agreed upon between the facility, the employer and the medical provider. Services and procedures thus rendered are payable according to a pre- negotiated fee arrangement between the facility and the employer, a relevant pre-existing contract or at the inpatient rate if no

[1] See 78 FR 43622 Addendum E

other agreement has been reached. The fee agreement must be memorialized in writing prior to performing the medical service or procedure.

This provision is in furtherance of the CMS practice of using the least restrictive setting for the procedure to be performed.

Physical Therapy - Medicare caps on the number of approved visits per year shall not apply to physical therapy performed in a hospital setting.

Repackaged Drugs - Medical service providers billing for repackaged legend drugs under IC 22-3-3-4.5 must include both the repackaged NDC and the original manufacturer's NDC, in that order, on the bill.

Applicable Interest Rate - Effective 1-1-2023, per IC 22-3-7.2-6, interest will be due on late payments of clean claims. Simple interest should be calculated at 1%, based on IC 12-15-21-3(7)(A) and the published rate of .64% in the most recent Annual Comprehensive Financial Report (2021).

Obligation to Pay - While providers have been instructed to submit bills for services to injured workers to employers within 120 days of service pursuant to 631 IAC 1-1-32(2)(A)(i), the Board's position is that valid invoices for such services cannot be denied for violating this regulation. See IC 22-3-3-5(c). Regulations are intended to assist with the enforcement of statutes and cannot grant or deprive rights otherwise conferred by law.

Conflicts - To the extent that IC 22-3-7.2 conflicts with any regulation, the statute takes precedence.

Procedural guidance on hospital and facility claims process is available under the Providers tab. The Board also wishes to thank the many professionals who contributed to these Guidelines through the kind sharing of their knowledge, wisdom and experience. Finally, while we provide this information to be of assistance, it is not law, and should not be read as such.