ENGROSSED
SENATE BILL No. 310

DIGEST OF SB 310 (Updated April 10, 2001 5:04 PM - DI 97)

Citations Affected: IC 5-10; IC 12-15; IC 27-8; IC 27-13.

Synopsis: Updating reimbursement codes. Requires the following entities to begin using, not later than 90 days after the effective date, the most current version of specified diagnostic and procedure codes under which claims for health care services are submitted and paid: (1) an administrator of a state employee health benefit plan; (2) the office of Medicaid policy and planning; (3) an insurer that provides coverage for medical expenses; (4) an insurer that issues a worker's compensation policy; (5) an employer who has received a certificate from the worker's compensation board to carry its own worker's compensation risk without insurance; (6) the Indiana comprehensive health insurance association; (7) a health maintenance organization; (8) a limited service health maintenance organization; and (9) providers of covered health care services. Requires payors to reimburse providers for covered services based on updated codes if the services are provided after the effective date of the updated codes.

Effective: July 1, 2001.

Miller, Craycraft
(HOUSE SPONSORS — PELATH, RIPLEY)

ENGROSSED
SENATE BILL No. 310

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

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

1   SECTION 1. IC 5-10-8-11 IS ADDED TO THE INDIANA CODE
2 AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
3 1, 2001]: **Sec. 11. (a) As used in this section, "administrator"**
4 **means:**
5   **(1) the state personnel department;**
6   **(2) an entity with which the state contracts to administer**
7   **health coverage under section 7(b) of this chapter; or**
8   **(3) a prepaid health care delivery plan with which the state**
9   **contracts under section 7(c) of this chapter.**
10   **(b) As used in this section, "health care plan" has the meaning**
11 **set forth in section 7.7 of this chapter.**
12   **(c) As used in this section, "provider" has the meaning set forth**
13 **in IC 27-8-11-1.**
14   **(d) Not more than ninety (90) days after the effective date of a**
15 **diagnostic or procedure code described in this subsection:**
16   **(1) an administrator shall begin using the most current**
17   **version of the:**

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1   **(A) current procedural terminology (CPT);**
2   **(B) international classification of diseases (ICD);**
3   **(C) American Psychiatric Association's Diagnostic and**
4   **Statistical Manual of Mental Disorders (DSM);**
5   **(D) current dental terminology (CDT);**
6   **(E) Health Care Financing Administration's common**
7   **procedure coding system (HCPCS); and**
8   **(F) third party administrator (TPA);**
9   **codes under which the administrator pays claims for services**
10   **provided under a health care plan; and**
11   **(2) a provider shall begin using the most current version of**
12   **the:**
13   **(A) current procedural terminology (CPT);**
14   **(B) international classification of diseases (ICD);**
15   **(C) American Psychiatric Association's Diagnostic and**
16   **Statistical Manual of Mental Disorders (DSM);**
17   **(D) current dental terminology (CDT);**
18   **(E) Health Care Financing Administration's common**
19   **procedure coding system (HCPCS); and**
20   **(F) third party administrator (TPA);**
21   **codes under which the provider submits claims for payment**
22   **for services provided under a health care plan.**
23   **(e) If a provider provides services that are covered under a**
24 **health care plan:**
25   **(1) after the effective date of the most current version of a**
26   **diagnostic or procedure code described in subsection (d); and**
27   **(2) before the administrator begins using the most current**
28   **version of the diagnostic or procedure code;**
29 **the administrator shall reimburse the provider under the version**
30 **of the diagnostic or procedure code that was in effect on the date**
31 **that the services were provided.**
32   SECTION 2. IC 12-15-13-7.2 IS ADDED TO THE INDIANA
33 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
34 [EFFECTIVE JULY 1, 2001]: **Sec. 7.2. (a) As used in this section,**
35 **"provider" has the meaning set forth in IC 27-8-11-1.**
36   **(b) Not more than ninety (90) days after the effective date of a**
37 **diagnostic or procedure code described in this subsection:**
38   **(1) the office shall begin using the most current version of the:**
39   **(A) current procedural terminology (CPT);**
40   **(B) international classification of diseases (ICD);**
41   **(C) American Psychiatric Association's Diagnostic and**
42   **Statistical Manual of Mental Disorders (DSM);**

1   **(D) current dental terminology (CDT);**

2   **(E) Health Care Financing Administration's common**

3   **procedure coding system (HCPCS); and**

4   **(F) third party administrator (TPA);**

5   **codes under which the office pays claims for services provided**

6   **under the Medicaid program; and**

7   **(2) a provider shall begin using the most current version of**

8   **the:**

9   **(A) current procedural terminology (CPT);**

10   **(B) international classification of diseases (ICD);**

11   **(C) American Psychiatric Association's Diagnostic and**

12   **Statistical Manual of Mental Disorders (DSM);**

13   **(D) current dental terminology (CDT);**

14   **(E) Health Care Financing Administration's common**

15   **procedure coding system (HCPCS); and**

16   **(F) third party administrator (TPA);**

17   **codes under which the provider submits claims for payment**

18   **for services provided under the Medicaid program.**

19   **(c) If a provider provides services that are covered under the**

20 **Medicaid program:**

21   **(1) after the effective date of the most current version of a**

22   **diagnostic or procedure code described in subsection (b); and**

23   **(2) before the office begins using the most current version of**

24   **the diagnostic or procedure code;**

25 **the office shall reimburse the provider under the version of the**

26 **diagnostic or procedure code that was in effect on the date that the**

27 **services were provided.**

28   SECTION 3. IC 27-8-10-11.2 IS ADDED TO THE INDIANA

29 CODE AS A **NEW** SECTION TO READ AS FOLLOWS

30 [EFFECTIVE JULY 1, 2001]: **Sec. 11.2. (a) Not more than ninety**

31 **(90) days after the effective date of a diagnostic or procedure code**

32 **described in this subsection:**

33   **(1) the association shall begin using the most current version**

34   **of the:**

35   **(A) current procedural terminology (CPT);**

36   **(B) international classification of diseases (ICD);**

37   **(C) American Psychiatric Association's Diagnostic and**

38   **Statistical Manual of Mental Disorders (DSM);**

39   **(D) current dental terminology (CDT);**

40   **(E) Health Care Financing Administration's common**

41   **procedure coding system (HCPCS); and**

42   **(F) third party administrator (TPA);**

codes under which the association pays claims for services
provided under an association policy; and
  (2) a health care provider shall begin using the most current
  version of the:
      (A) current procedural terminology (CPT);
      (B) international classification of diseases (ICD);
      (C) American Psychiatric Association's Diagnostic and
      Statistical Manual of Mental Disorders (DSM);
      (D) current dental terminology (CDT);
      (E) Health Care Financing Administration's common
      procedure coding system (HCPCS); and
      (F) third party administrator (TPA);
  codes under which the health care provider submits claims for
  payment for services provided under an association policy.
    (b) If a health care provider provides services that are covered
under an association policy:
    (1) after the effective date of the most current version of a
    diagnostic or procedure code described in subsection (a); and
    (2) before the association begins using the most current
    version of the diagnostic or procedure code;
the association shall reimburse the health care provider under the
version of the diagnostic or procedure code that was in effect on
the date that the services were provided.
    SECTION 4. IC 27-8-22.1 IS ADDED TO THE INDIANA CODE
AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE
JULY 1, 2001]:
    Chapter 22.1. Claims
    Sec. 1. As used in this chapter, "accident and sickness insurance
policy" means an insurance policy that provides at least one (1) of
the types of insurance described in IC 27-1-5-1, Classes 1(b), 2(a),
2(b), 2(e), 2(f), and 2(h).
    Sec. 2. As used in this chapter, "insurer" means:
    (1) an insurer that issues:
        (A) an accident and sickness insurance policy; or
        (B) a worker's compensation policy; or
    (2) an employer who has received a certificate from the
    worker's compensation board to carry the employer's
    worker's compensation risk without insurance under
    IC 22-3-2-5.
    Sec. 3. As used in this chapter, "provider" has the meaning set
forth in IC 27-8-11-1.
    Sec. 4. As used in this chapter, "worker's compensation policy"

1 **means a policy of insurance issued to an employer under**
2 **IC 22-3-2-5.**
3   **Sec. 5. (a) Not more than ninety (90) days after the effective date**
4 **of a diagnostic or procedure code described in this subsection:**
5   **(1) an insurer shall begin using the most current version of**
6   **the:**
7   **(A) current procedural terminology (CPT);**
8   **(B) international classification of diseases (ICD);**
9   **(C) American Psychiatric Association's Diagnostic and**
10   **Statistical Manual of Mental Disorders (DSM);**
11   **(D) current dental terminology (CDT);**
12   **(E) Health Care Financing Administration's common**
13   **procedure coding system (HCPCS); and**
14   **(F) third party administrator (TPA);**
15   **codes under which the insurer pays claims for services**
16   **provided under an accident and sickness insurance policy or**
17   **a worker's compensation policy; and**
18   **(2) a provider shall begin using the most current version of**
19   **the:**
20   **(A) current procedural terminology (CPT);**
21   **(B) international classification of diseases (ICD);**
22   **(C) American Psychiatric Association's Diagnostic and**
23   **Statistical Manual of Mental Disorders (DSM);**
24   **(D) current dental terminology (CDT);**
25   **(E) Health Care Financing Administration's common**
26   **procedure coding system (HCPCS); and**
27   **(F) third party administrator (TPA);**
28   **codes under which the provider submits claims for payment**
29   **for services provided under an accident and sickness**
30   **insurance policy or a worker's compensation policy.**
31   **(b) If a provider provides services that are covered under an**
32 **accident and sickness insurance policy or a worker's compensation**
33 **policy:**
34   **(1) after the effective date of the most current version of a**
35   **diagnostic or procedure code described in subsection (a); and**
36   **(2) before the insurer begins using the most current version of**
37   **the diagnostic or procedure code;**
38 **the insurer shall reimburse the provider under the version of the**
39 **diagnostic or procedure code that was in effect on the date that the**
40 **services were provided.**
41   SECTION 5. IC 27-13-41 IS ADDED TO THE INDIANA CODE
42 AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE

JULY 1, 2001]:

Chapter 41. Claims

Sec. 1. Not more than ninety (90) days after the effective date of a diagnostic or procedure code described in this section:

> **(1) a health maintenance organization and a limited service health maintenance organization shall begin using the most current version of the:**
>
> > **(A) current procedural terminology (CPT);**
> > **(B) international classification of diseases (ICD);**
> > **(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);**
> > **(D) current dental terminology (CDT);**
> > **(E) Health Care Financing Administration's common procedure coding system (HCPCS); and**
> > **(F) third party administrator (TPA);**
>
> **codes under which the health maintenance organization and limited service health maintenance organization pay claims for health care services covered under an individual contract or a group contract; and**
>
> **(2) a provider shall begin using the most current version of the:**
>
> > **(A) current procedural terminology (CPT);**
> > **(B) international classification of diseases (ICD);**
> > **(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);**
> > **(D) current dental terminology (CDT);**
> > **(E) Health Care Financing Administration's common procedure coding system (HCPCS); and**
> > **(F) third party administrator (TPA);**
>
> **codes under which the provider submits claims for payment for health care services covered under an individual contract or a group contract.**

Sec. 2. If a provider provides health care services that are covered under an individual contract or a group contract:

> **(1) after the effective date of the most current version of a diagnostic or procedure code described in section 1 of this chapter; and**
> **(2) before the health maintenance organization or limited service health maintenance organization begins using the most current version of the diagnostic or procedure code;**

the health maintenance organization or limited service health maintenance organization shall reimburse the provider under the

1   **version of the diagnostic or procedure code that was in effect on**
2   **the date that the health care services were provided.**

SENATE MOTION

Mr. President: I move that Senator Craycraft be added as second author of Senate Bill 310.

MILLER

COMMITTEE REPORT

Mr. President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 310, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 1, line 17, delete "and".

Page 2, between lines 1 and 2, begin a new line double block indented and insert:

"(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) current dental terminology (CDT);

(E) Health Care Financing Administration's common procedure coding system (HCPCS); and

(F) third party administrator (TPA);".

Page 2, line 6, delete "and".

Page 2, between lines 7 and 8, begin a new line double block indented and insert:

"(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) current dental terminology (CDT);

(E) Health Care Financing Administration's common procedure coding system (HCPCS); and

(F) third party administrator (TPA);".

Page 2, line 16, delete "and".

Page 2, between lines 17 and 18, begin a new line double block indented and insert:

"(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) current dental terminology (CDT);

(E) Health Care Financing Administration's common procedure coding system (HCPCS); and

(F) third party administrator (TPA);".

Page 2, line 22, delete "and".

Page 2, between lines 23 and 24, begin a new line double block indented and insert:

"(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) current dental terminology (CDT);

(E) Health Care Financing Administration's common procedure coding system (HCPCS); and

(F) third party administrator (TPA);".

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Page 2, line 31, delete "and".

Page 2, between lines 32 and 33, begin a new line double block indented and insert:

"(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) current dental terminology (CDT);

(E) Health Care Financing Administration's common procedure coding system (HCPCS); and

(F) third party administrator (TPA);".

Page 2, line 37, delete "and".

Page 2, between lines 38 and 39, begin a new line double block indented and insert:

"(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) current dental terminology (CDT);

(E) Health Care Financing Administration's common procedure coding system (HCPCS); and

(F) third party administrator (TPA);".

Page 3, delete lines 7 through 8, begin a new paragraph and insert:

"Sec. 2. As used in this chapter, "insurer" means:

(1) an insurer that issues:

(A) an accident and sickness insurance policy; or

(B) a worker's compensation policy; or

(2) an employer who has received a certificate from the worker's compensation board to carry its worker's compensation risk without insurance under IC 22-3-2-5.".

Page 3, between lines 10 and 11, begin a new paragraph and insert:

"Sec. 4. As used in this chapter, "worker's compensation policy" means a policy of insurance issued to an employer under IC 22-3-2-5.".

Page 3, line 11, delete "4" and insert "**5**".

Page 3, line 14, delete "and".

Page 3, between lines 15 and 16, begin a new line double block indented and insert:

"(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) current dental terminology (CDT);

(E) Health Care Financing Administration's common procedure coding system (HCPCS); and

(F) third party administrator (TPA);".

Page 3, line 21, delete "and".

Page 3, between lines 22 and 23, begin a new line double block

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indented and insert:

"(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);
(D) current dental terminology (CDT);
(E) Health Care Financing Administration's common procedure coding system (HCPCS); and
(F) third party administrator (TPA);".

Page 3, line 34, delete "and".

Page 3, between lines 35 and 36, begin a new line double block indented and insert:

"(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);
(D) current dental terminology (CDT);
(E) Health Care Financing Administration's common procedure coding system (HCPCS); and
(F) third party administrator (TPA);".

Page 3, line 42, delete "and".

Page 4, between lines 1 and 2, begin a new line double block indented and insert:

"(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);
(D) current dental terminology (CDT);
(E) Health Care Financing Administration's common procedure coding system (HCPCS); and
(F) third party administrator (TPA);".

and when so amended that said bill do pass.

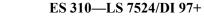(Reference is to SB 310 as introduced.)

MILLER, Chairperson

Committee Vote: Yeas 11, Nays 0.

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SENATE MOTION

Mr. President: I move that Senate Bill 310 be amended to read as follows:

Page 1, line 14, delete "On January 1 of each year:" and insert "**Not more than ninety (90) days after the effective date of a diagnostic or procedure code described in this subsection:**".

Page 2, between lines 21 and 22, begin a new paragraph and insert:

"**(e) If a provider provides services that are covered under a health care plan:**

> **(1) after the effective date of the most current version of a diagnostic or procedure code described in subsection (d); and**
> **(2) before the administrator begins using the most current version of the diagnostic or procedure code;**

the administrator shall reimburse the provider under the version of the diagnostic or procedure code that was in effect on the date that the services were provided.".

Page 2, line 26, delete "On January 1 of each year:" and insert "**Not more than ninety (90) days after the effective date of a diagnostic or procedure code described in this subsection:**".

Page 3, between lines 7 and 8, begin a new paragraph and insert:

"**(c) If a provider provides services that are covered under the Medicaid program:**

> **(1) after the effective date of the most current version of a diagnostic or procedure code described in subsection (b); and**
> **(2) before the office begins using the most current version of the diagnostic or procedure code;**

the office shall reimburse the provider under the version of the diagnostic or procedure code that was in effect on the date that the services were provided.

(d) Not less than thirty (30) days before the effective date of an updated version of the current procedural terminology (CPT) and international classification of disease (ICD) codes, the office shall transmit electronically the updated codes to all:

> **(1) providers of health care services; and**
> **(2) health maintenance organizations;**

that participate in Medicaid under this article.".

Page 3, line 10, delete "On January 1 of each year:" and insert "**(a) Not more than ninety (90) days after the effective date of a diagnostic or procedure code described in this subsection:**".

Page 3, between lines 34 and 35, begin a new paragraph and insert:

"**(b) If a provider provides services that are covered under an association policy:**

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(1) after the effective date of the most current version of a diagnostic or procedure code described in subsection (a); and

(2) before the association begins using the most current version of the diagnostic or procedure code;

the association shall reimburse the provider under the version of the diagnostic or procedure code that was in effect on the date that the services were provided.".

Page 4, line 13, delete "On January 1 of each year:" and insert "**(a) Not more than ninety (90) days after the effective date of a diagnostic or procedure code described in this subsection:**".

Page 4, line 25, delete ";" and insert "**or a worker's compensation policy;**".

Page 4, line 39, delete "." and insert "**or a worker's compensation policy.**".

Page 4, between lines 39 and 40, begin a new paragraph and insert:

"**(b) If a provider provides services that are covered under an accident and sickness insurance policy or a worker's compensation policy:**

(1) after the effective date of the most current version of a diagnostic or procedure code described in subsection (a); and

(2) before the insurer begins using the most current version of the diagnostic or procedure code;

the insurer shall reimburse the provider under the version of the diagnostic or procedure code that was in effect on the date that the services were provided.".

Page 5, line 2, delete "On January 1 of each year:" and insert "**Not more than ninety (90) days after the effective date of a diagnostic or procedure code described in this section:**".

Page 5, after line 30, begin a new paragraph and insert:

"**Sec. 2. If a provider provides services that are covered under an individual contract or a group contract:**

(1) after the effective date of the most current version of a diagnostic or procedure code described in section 1 of this chapter; and

(2) before the health maintenance organization or limited service health maintenance organization begins using the most current version of the diagnostic or procedure code;

the health maintenance organization or limited service health maintenance organization shall reimburse the provider under the

version of the diagnostic or procedure code that was in effect on the date that the services were provided.".

(Reference is to SB 310 as printed January 26, 2001.)

MILLER

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COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, Corporations and Small Business, to which was referred Senate Bill 310, 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 2, line 32, delete "IC 12-15-13-7" and insert "IC 12-15-13-7.2".

Page 2, line 34, delete "7." and insert "**7.2.**".

Page 3, delete lines 28 through 34.

Page 3, line 35, delete "IC 27-8-10-11" and insert "IC 27-8-10-11.2".

Page 3, line 37, delete "11." and insert "**11.2.**".

Page 4, line 10, after "a" insert "**health care**".

Page 4, line 20, after "the" insert "**health care**".

Page 4, line 22, after "a" insert "**health care**".

Page 4, line 28, after "reimburse the" insert "**health care**".

Page 5, line 2, delete "its" and insert "**the employer's**".

Page 6, line 39, after "provides" insert "**health care**".

Page 7, line 8, after "that the" insert "**health care**".

and when so amended that said bill do pass.

(Reference is to SB 310 as reprinted February 2, 2001.)

CROOKS, Chair

Committee Vote: yeas 11, nays 0.

HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 310 be amended to read as follows:

Page 4, line 30, delete "and" and insert "**,**".

Page 4, line 31, delete "." and insert "**, 2(b), 2(e), 2(f), and 2(h).**".

(Reference is to ESB 310 as printed April 6, 2001.)

PELATH

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