Reprinted
February 2, 2001

SENATE BILL No. 310

DIGEST OF SB 310 (Updated February 1, 2001 2:37 PM - DI 98)

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 accident and sickness insurer; (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 health care services that are covered under a state employee health benefit plan, Indiana Medicaid, an accident and sickness insurance policy, a worker's compensation policy, an employer who has received a certificate from the worker's compensation board to carry its own worker's compensation risk without insurance, an Indiana comprehensive health insurance association policy, a health maintenance organization contract, or a limited service health maintenance organization. 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. Requires the office of Medicaid policy and planning to electronically transmit updated codes to providers and health maintenance organizations that participate in the Medicaid program at least 30 days before the effective date of the updated codes.

Effective: July 1, 2001.

Miller, Craycraft

January 11, 2001, read first time and referred to Committee on Health and Provider Services.
January 25, 2001, amended, reported favorably — Do Pass.
February 1, 2001, read second time, amended, ordered engrossed.

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First Regular Session 112th General Assembly (2001)

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 2000 General Assembly.

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:

SECTION 1. IC 5-10-8-11 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 11. (a) As used in this section, "administrator" means:**

(1) the state personnel department;

(2) an entity with which the state contracts to administer health coverage under section 7(b) of this chapter; or

(3) a prepaid health care delivery plan with which the state contracts under section 7(c) of this chapter.

(b) As used in this section, "health care plan" has the meaning set forth in section 7.7 of this chapter.

(c) As used in this section, "provider" has the meaning set forth in IC 27-8-11-1.

(d) Not more than ninety (90) days after the effective date of a diagnostic or procedure code described in this subsection:

(1) an administrator 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 administrator pays claims for services provided under a health care plan; 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 services provided under a health care plan.

(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.

SECTION 2. IC 12-15-13-7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 7. (a) As used in this section, "provider" has the meaning set forth in IC 27-8-11-1.**

(b) Not more than ninety (90) days after the effective date of a diagnostic or procedure code described in this subsection:

(1) the office 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 office pays claims for services provided under the Medicaid program; 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 services provided under the Medicaid program.

(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.

SECTION 3. IC 27-8-10-11 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 11. (a) Not more than ninety (90) days after the effective date of a diagnostic or procedure code described in this subsection:**

(1) the association 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 association pays claims for services provided under an association policy; 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 services provided under an association policy.

(b) If a 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 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) and 2(a).

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.

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" means a policy of insurance issued to an employer under IC 22-3-2-5.

Sec. 5. (a) Not more than ninety (90) days after the effective date of a diagnostic or procedure code described in this subsection:

(1) an insurer 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 insurer pays claims for services provided under an accident and sickness insurance policy or a worker's compensation policy; 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 services provided under an accident and sickness insurance policy or a worker's compensation policy.

(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.

SECTION 5. IC 27-13-41 IS ADDED TO THE INDIANA CODE 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 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.

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);".

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

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.

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:**

(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