SENATE MOTION

MR. PRESIDENT:

I move that Senate Bill 137 be amended to read as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 5-10-8-11, AS ADDED BY P.L.161-2001, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: 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~~ **Healthcare** 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~~ **Healthcare** 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.".

Page 2, between lines 26 and 27, begin a new paragraph and insert:

"SECTION 4. IC 12-15-13-7.2, AS ADDED BY P.L.161-2001, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 7.2. (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~~ **Healthcare** 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~~ **Healthcare** 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.".

Page 10, between lines 35 and 36, begin a new paragraph and insert:

"SECTION 15. IC 27-8-10-11.2, AS ADDED BY P.L.161-2001, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 11.2. (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~~ **Healthcare** 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 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~~ **Healthcare** 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 16. IC 27-8-22.1-5, AS ADDED BY P.L.161-2001, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: 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~~ **Healthcare** 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~~ **Healthcare** 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.".

Page 11, after line 19, begin a new paragraph and insert:

"SECTION 18. IC 27-13-41-1, AS ADDED BY P.L.161-2001, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: 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~~ **Healthcare** 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~~ **Healthcare** 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.".

Renumber all SECTIONS consecutively.

(Reference is to SB 137 as printed January 11, 2002.)

_____

Senator MILLER